

VITREOUS FLOATER SOLUTIONS QUESTIONNAIRE

How did you first hear about us?

Who is your regular eye doctor? name city

Patient Name: _____ Sex: **M / F** DOB: _____

Home address: _____ City: _____ State: _____ Zip: _____

Work address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

email address: _____

Occupation _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Type of Correction: **Glasses / Contact Lenses / Both** Contact Lens type: **Soft / Hard**

Medications you're taking: _____

Medication or Drug Allergies? **No / Yes** (if yes, what are they): _____

Hobbies/ Special Visual needs: _____

How did you hear about us: _____

Did a friend or colleague refer you to our office? Who?: _____

How do you prefer we contact you if necessary: _____

Have you ever had any of the following conditions

(mark with an "x")

- previous eye surgery
- previous laser eye surgery
- glaucoma
- arthritis
- diabetes
- headaches (severe)
- heart problems
- hepatitis
- HIV +
- autoimmune disorders (e.g. Lupus)

Which eye(s) are affected by Floaters? RIGHT / LEFT / BOTH

Which is worse? RIGHT / LEFT / SAME

When did you first become aware of Floaters?

RIGHT: _____

LEFT: _____

Were your eyes examined for the floaters? YES / NO

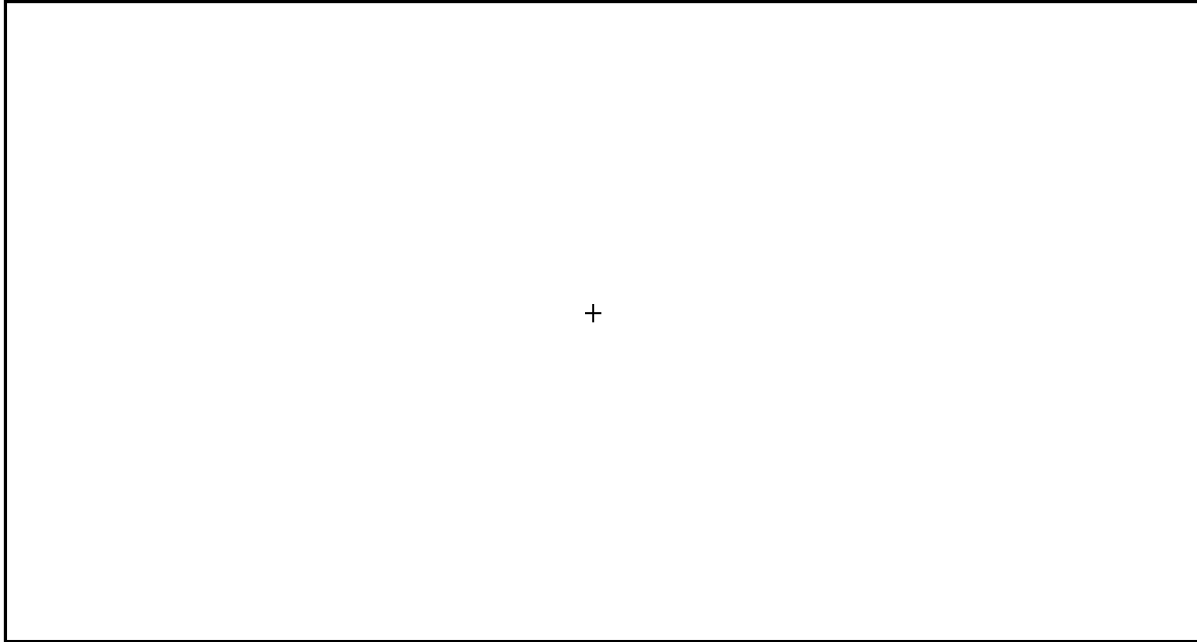
What were you told?: _____

Do you experience any flashes of light? YES / NO

Bring this drawing with you to your first evaluation/consultation visit

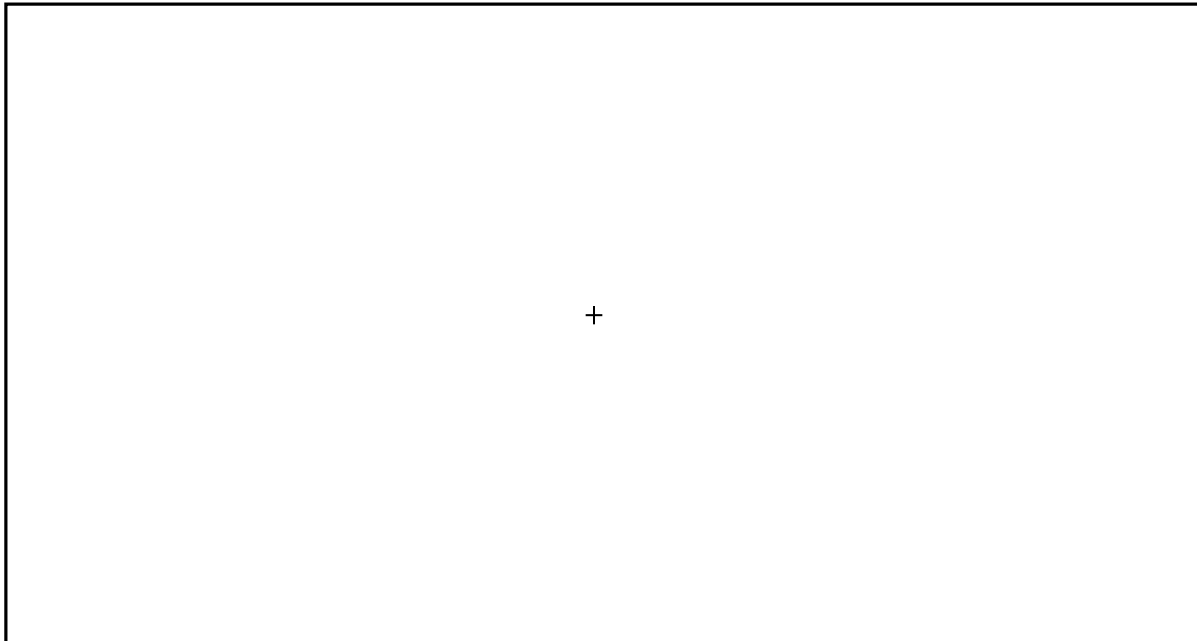
Please draw what the floaters look like to you as if looking into a big white panel approximately one yard/meter away from you. Show where the floaters usually appear when still and looking straight ahead. Use arrows to show typical movement direction.

RIGHT EYE



[] prior to any treatment

LEFT EYE



[] prior to any treatment

Name: _____ Date: _____

CASE REPORT STUDY QUESTIONNAIRE
PART ONE: BEFORE TREATMENT

NAME: _____ DATE: _____

1. FLOATERS BOTHER/DISTURB ME IN: (CHECK ONE ONLY)

- RIGHT EYE PRIMARILY
- LEFT EYE PRIMARILY
- BOTH EYES (TO SOME DEGREE)

2. HOW LONG HAVE YOU HAD BOTHERSOME OR DISTRACTING FLOATERS ? (APPROXIMATE / BEST GUESS)

RIGHT EYE: _____ YEARS, _____ MONTHS

LEFT EYE: _____ YEARS, _____ MONTHS

3. WHAT ARE YOUR RISK FACTORS FOR EYE FLOATERS? (CHECK ALL THAT APPLY)

- AGE OVER 40
- MYOPIA / NEAR-SIGHTED
- TRAUMA / INJURY / SURGERY / LASIK
- HISTORY OF SIGNIFICANT INFLAMMATION REQUIRING MEDICAL TREATMENT (IRITIS / UVEITIS)

4. HAVE YOU HAD A PUPIL-DILATED EXAM SINCE THE ONSET OF YOUR EYE FLOATERS?

- NO
- YES

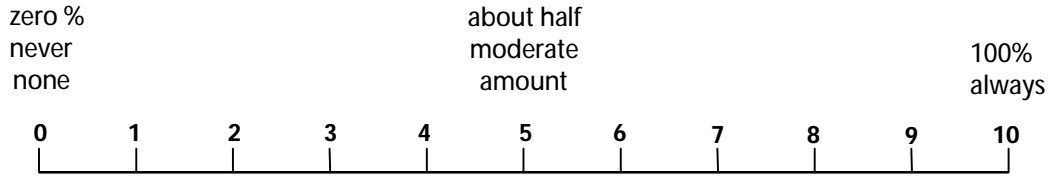
5. IF YOU DID HAVE A DILATED EXAM, WAS YOUR DOCTOR ABLE TO SEE/CONFIRM THE FLOATERS?

- NOT APPLICABLE, HAVEN'T HAD EXAM
- NO, THEY COULD NOT SEE THE FLOATERS
- YES
- NOT SURE IF THEY SAW THE FLOATERS

6. IF YOUR EYE DOCTOR CONFIRMED OR DIAGNOSED THE EYE FLOATERS, WHAT WAS THE ADVICE YOU WERE GIVEN (CHOOSE ONE OR MORE THAT BEST DESCRIBE):

- NOT APPLICABLE, HAVEN'T SEEN DOCTOR
- NO ADVICE GIVEN OR CAN'T REMEMBER ANY SPECIFIC ADVICE
- TOLD: " YOU WILL GET USED TO IT"
- TOLD: " IT WILL MOVE OUT OF THE WAY"
- TOLD: " IT WILL DISAPPEAR OR DISSOLVE ON ITS OWN"
- OTHER: _____

B. TO WHAT DEGREE DO EYE FLOATERS INTERRUPT / DISTRACT / ANNOY YOU **IN GENERAL / OVERALL**?



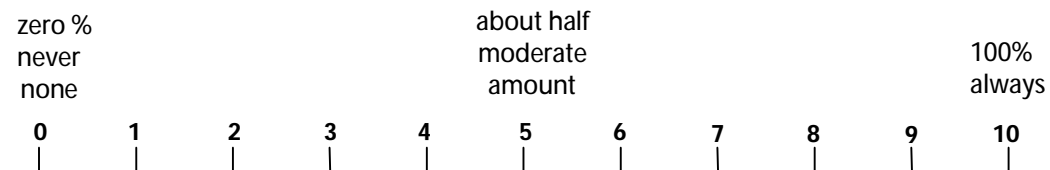
C. TO WHAT DEGREE DO EYE FLOATERS INTERRUPT / DISTRACT / ANNOY YOU WHEN **DRIVING**?



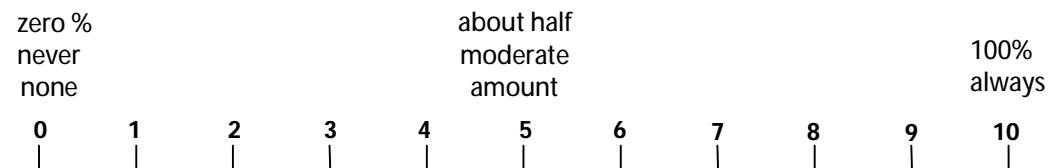
D. TO WHAT DEGREE DO EYE FLOATERS INTERRUPT / DISTRACT / ANNOY YOU WHEN **READING OR COMPUTER ACTIVITIES**?



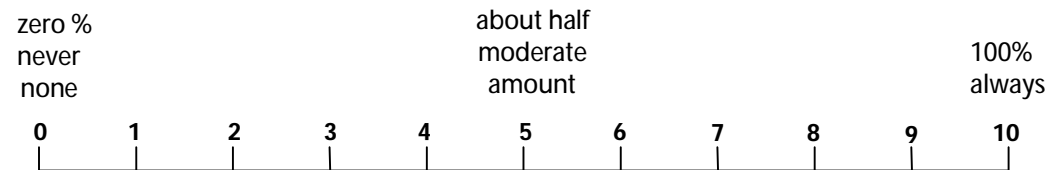
E. TO WHAT DEGREE DO EYE FLOATERS INTERRUPT / DISTRACT / ANNOY YOU WHEN **INTERACTING SOCIALLY ONE-ON-ONE WITH OTHERS**?



F. TO WHAT DEGREE DO THE EYE FLOATERS CAUSE OR CONTRIBUTE TO **ANXIETY IN YOUR LIFE**?

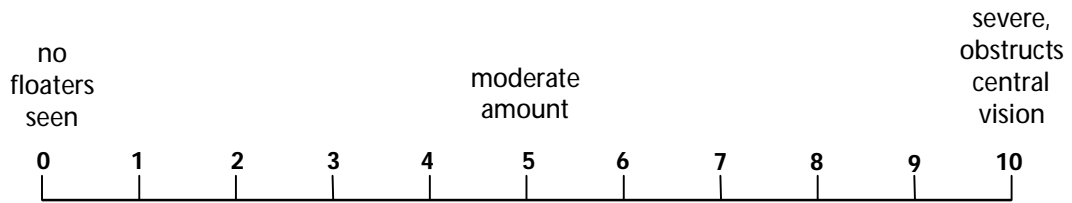


G. TO WHAT DEGREE DO THE EYE FLOATERS CAUSE OR CONTRIBUTE TO **DEPRESSION IN YOUR LIFE**?

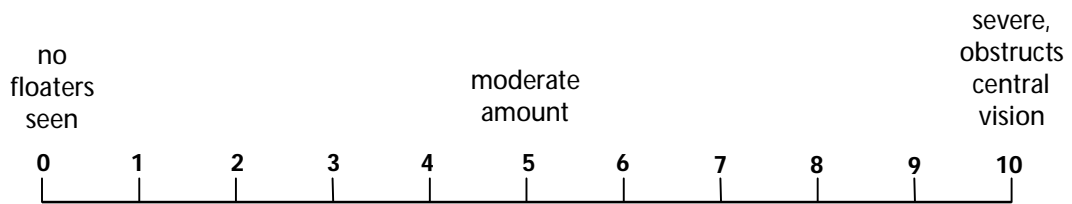


H. TRY TO DESCRIBE THE OVERALL SEVERITY OF YOUR FLOATER FOR EACH EYE SEPARATELY. THIS IS COMPLETELY SUBJECTIVE, BUT WILL GIVE US A BASELINE TO COMPARE TO AFTER ANY TREATMENT PERFORMED.

RIGHT EYE:



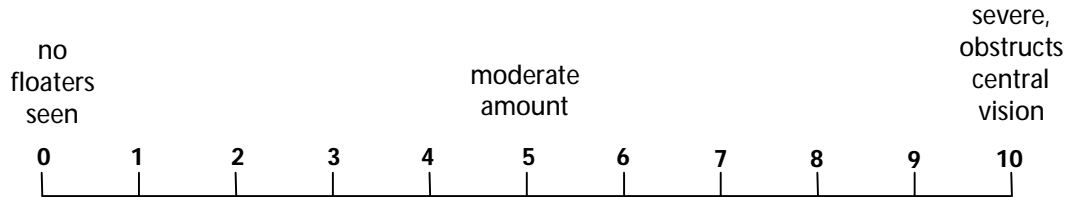
LEFT EYE:



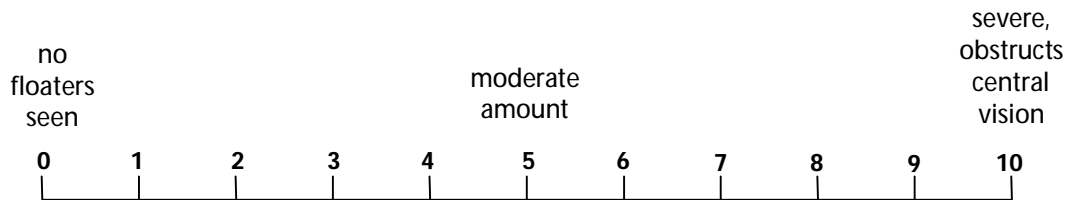
POST-TREATMENT ASSESSMENT:

USING THE SAME SCALE AS BEFORE TREATMENT, PLACE A MARK THAT BEST DESCRIBES THE OVERALL SEVERITY OF THE EYE FLOATER(S).

RIGHT EYE: ASSESSMENT AFTER 1 TREATMENT, 2 TREATMENTS, 3 TREATMENTS
 _____ TREATMENTS



LEFT EYE: ASSESSMENT AFTER 1 TREATMENT, 2 TREATMENTS, 3 TREATMENTS
 _____ TREATMENTS



NAME: _____ DATE: _____