

**CATARACT SURGERY REGISTRY (CSR):
PRE-CLERKING RECORD**

Office use: /
Centre:

*Instruction: This form is to be filled for patient who is going to have Cataract Surgery but excluded secondary IOL Implantation. Where check boxes are provided, check (✓) one or more boxes. Where radio buttons are provided, check (✓) one box only.
* indicates compulsory field.*

i.) Hospital / Clinic: _____ ii) Date : / /

SECTION 1 : PATIENT PARTICULARS

*1 Patient Name: _____
 *2 Identification Card Number: My Kad / MyKid - - Old I.C.:
 If MyKad/MyKid is not available, please complete the Old I.C. or Other ID document No. Other ID document No: → Specify type (eg. Passport, armed force ID):
 3. Address: Postcode: Town/ City: State:
 *4 a. Date of Birth: 4b. Age at notification: (in years) or (in months if < 1 yr old) Auto Calculated
 *5 Gender: Male Female 6. Ethnic Group: Malay Orang Asli Bidayah
 Chinese Melanau Iban
 Indian Kadazan/Murut/Bajau Others, specify: _____

SECTION 2: MEDICAL HISTORY (check one box as appropriate)

*1. Surgery On:
 First eye Date of first eye surgery: _____
 Second eye → Intra-op complications: Yes No
 2. Past Ocular Surgery of the Eye to be operated
 None Filtering Surgery
 Vitreoretinal Surgery Pterygium Excision
 Penetrating Keratoplasty Others, specify: _____
 3. Cause of Cataract
 Primary OR Secondary
 a) If primary: Senile/age related Trauma
 Congenital Drug Induced
 Developmental Surgery Induced
 Others _____ Others _____

*4. Ocular Comorbidity (check one or more boxes below if present)
 None
 a) ANTERIOR SEGMENT:
 Pterygium involving the cornea
 Corneal Opacity
 Glaucoma
 Chronic Uveitis
 Pseudoexfoliation
 Lens Related Complications
 Phacomorphic
 Phacolytic
 Subluxated/ Dislocated
 b) MISCELLANEOUS:
 Amblyopia
 Significant previous eye trauma
 Pre-existing non glaucoma field defect (eg. CVA)
 c) POSTERIOR SEGMENT
 Diabetic Retinopathy
 Non Proliferative Diabetic Retinopathy
 Proliferative Diabetic Retinopathy
 Maculopathy
 Vitreous haemorrhage
 ARMD
 Other macular disease (includes hole or scar)
 Optic nerve disease, any type
 Retinal detachment
 Cannot be assessed
 Other ocular comorbidity, specify: _____

5. Systemic Comorbidity (check one or more boxes below if present)
 None Renal Failure
 Hypertension Cerebrovascular accident
 Diabetes Melitus COAD/ Asthma
 Ischaemic Heart Disease
 Others, specify: _____

SECTION 4: BIOMETRY TECHNIQUE & PLANNED REFRACTIVE POWER FOR OPERATED EYE

*1 Biometry Technique
 Indentation Immersion Interferometry Laser
 Others, specify _____ NA
 2 Planned Refractive Power _____
 +
 -
 NA

SECTION 3: PREOPERATIVE VISUAL ACUITY MEASUREMENT

(Please fill up at least one of the "presenting visual acuity" or "refracted visual acuity")

Vision	a) Right	b) Left
*1. Unaided:		
2. With glasses/ Pin Hole		
3. Refracted		
4. Refraction		
	Sp <input type="radio"/> + <input type="radio"/> -	<input type="radio"/> + <input type="radio"/> -
	<input type="radio"/> NA	<input type="radio"/> NA
	Cy	
	Axis	