

Please complete the following information to help us assess your suitability for Laser Vision Correction.

Name \_\_\_\_\_  
(last) (first)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone (home)    -    -       Email: \_\_\_\_\_

Telephone (work)    -    -       Primary Care MD: \_\_\_\_\_

Social Security Number    -    -       Address: \_\_\_\_\_

Date of Birth   /   /    Age   \_\_\_\_\_

month day year

- OCCUPATION:**
- White Collar / Clerical
  - Blue Collar / Craftsman
  - Management / Administrative
  - Sales / Service
  - Professional / Technical
  - Homemaker
  - Military
  - Religious
  - Student
  - Other:

- ACTIVITIES:**
- Water Sports
  - Racquetball
  - Tennis
  - Skiing
  - Snow Boarding
  - Sky Diving
  - Baseball
  - Football
  - Fitness Body Sculpting
  - Skating
  - Golf
  - Bicycling
  - Self-Defense
  - Aerobics
  - Camping
  - Hunting/Shooting
  - Boating
  - Scuba Diving
  - Soccer
  - Motorcycling
  - Running/Jogging

**Ocular History (Please mark an 'X' in the appropriate box)**

1. Do you wear eyeglasses, contact lenses or both to correct your vision?
  - Eyeglasses (go to Question 2)
  - Contact Lenses (Skip to Question 3)
  - Both eyeglasses and contact lenses (Skip to Question 3)
2. Have you ever worn contact lenses? (if no, skip to Question 6 after answering this question)
  - Yes  No
3. Do you wear soft or rigid contact lenses?
  - Soft  Rigid gas permeable/hard
4. Do you usually wear your contact lenses overnight while sleeping?
  - Yes  No
5. How often do you replace your contact lenses with a new pair?
  - Every day  Every 1-6 months
  - Every 1-2 weeks  Every 7 months or longer
6. Do you require bifocals or reading glasses for reading?
  - Yes  No
7. Has the prescription for your glasses and/or contact lenses been stable over time?
  - Yes  No

**Visit Day**
**Practice ID**
**Patient ID**

For questions 8,9,10,11 please draw a line through the scale at a point which best reflects your response.

For example: \_\_\_\_\_

8. How satisfied are you with the quality of your vision **without** glasses or contact lenses?

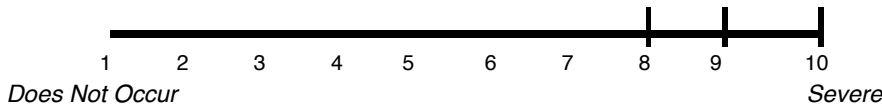


9. How satisfied are you with the quality of your vision **with** glasses or contact lenses?

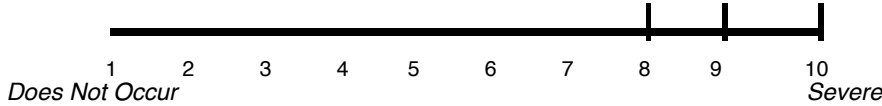


10. If you wear **glasses**, rate the severity of the following conditions while **wearing your glasses**.

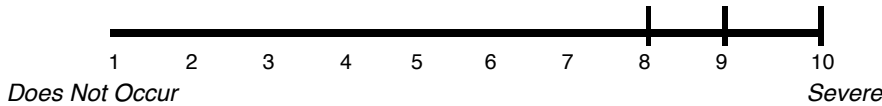
a) Glare



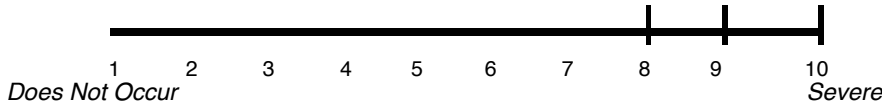
b) Halo or ring around light



c) Problems with vision during night driving



d) Difficulty reading



11. If you wear **contact lenses**, rate the severity of the following conditions while **wearing your contacts**.

a) Glare



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Visit Day

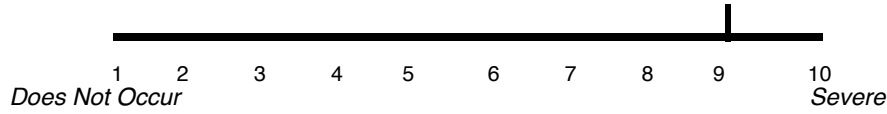
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Practice ID

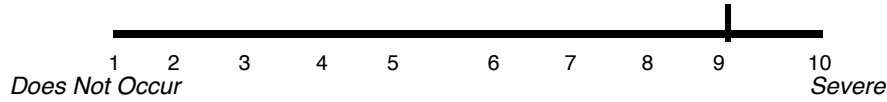
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Patient ID

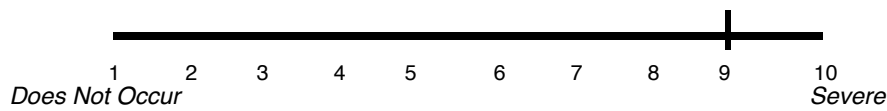
**b) Halo or ring around light**



**c) Problems with vision during night driving**



**d) Difficulty reading**



**e) Distortions or blurring of vision**



12. What percentage of the time do you wear glasses and/or contact lenses **for distance vision**:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0%	25%	50%	75%	100%

12b. What percentage of the time do you wear glasses and/or contact lenses **for near vision (reading)**:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0%	25%	50%	75%	100%

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**General Medical History** *(Please mark an 'X' in the appropriate box)*

13. Do you now or did you in the past have any of the following conditions?

	Yes	No	Please Specify
Allergies (medications)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies (other)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiac (heart) disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Collagen vascular diseases (Ex. Rheumatoid Arthritis)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal (stomach) disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of Keloid formation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus (SLE)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizure Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

If FEMALE, please complete the following:

Currently pregnant	<input type="checkbox"/>	<input type="checkbox"/>	_____
Currently nursing	<input type="checkbox"/>	<input type="checkbox"/>	_____

14. Do you use any eyedrops?

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	_____

15. Have you had any previous eye surgery?

<input type="checkbox"/>	<input type="checkbox"/>	_____
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16. Do you take any of the following medications?

	Yes	No	Please Specify
Antibiotics (for infection)	<input type="checkbox"/>	<input type="checkbox"/>	
Anticoagulants (to thin blood)	<input type="checkbox"/>	<input type="checkbox"/>	
Antidepressants	<input type="checkbox"/>	<input type="checkbox"/>	
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	
Blood pressure medications	<input type="checkbox"/>	<input type="checkbox"/>	
Corticosteroids	<input type="checkbox"/>	<input type="checkbox"/>	
Heart medications	<input type="checkbox"/>	<input type="checkbox"/>	
Insulin	<input type="checkbox"/>	<input type="checkbox"/>	
NSAIDs (Motrin, Advil etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric medications	<input type="checkbox"/>	<input type="checkbox"/>	
Seizure Medications	<input type="checkbox"/>	<input type="checkbox"/>	
Other, please specify	<input type="checkbox"/>	<input type="checkbox"/>	

**Family Medical History (Please mark an 'X' in the appropriate box)**

17. Has any close family member had any of the following conditions?

	Yes	No	Please Specify
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	
Corneal dystrophies	<input type="checkbox"/>	<input type="checkbox"/>	
Collagen vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	
Retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>	
Other, specify	<input type="checkbox"/>	<input type="checkbox"/>	

To the best of my knowledge, the preceding information is complete and correct

\_\_\_\_\_  
Patient Signature

Date: 

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month day year