

LASER VISION TREATMENT QUESTIONNAIRE

Name: _____

Today's Date: _____

Medical History:

- Do you have any current health conditions? (Arthritis, Diabetes, High Blood Pressure, Autoimmune Disease, Keloid Scarring, Pregnancy(Nursing), AIDS/HIV, Other?)

List _____ YES NO

- Have you had any previous eye conditions / injury / surgery? List _____ YES NO

- Do you take any medications? List _____ YES NO

- Are you allergic to any medications? List _____ YES NO

Including: **Latex:** YES NO Reaction _____ **Adhesive:** YES NO Reaction _____

- Has anyone else in your family had a refractive surgery procedure to correct their vision? (LASIK, PRK/LASEK, RK) YES NO

- Do you visit an eye doctor on a regular basis? YES NO if yes, please list his/her name(s) _____

When was your last eye exam? _____

Did your eye doctor discuss Laser Vision Correction? YES NO

What laser center(s) did he/she recommend? _____

Contact Lens / Glasses Wear:

- Do you currently wear contact lenses? YES NO How long since you last wore them? _____.

- How many years have you worn / used contacts? _____ Please indicate the type of contact lenses you wear now (or wore in the past):

Soft Rigid gas permeable Toric Overnight Wear Hard

- Please circle any other reasons for problems with glasses or contacts:

Poor comfort Poor peripheral vision Poor cosmetic appearance

Safety / Security Restricts my physical activity Occupational limitations

- What activities do you find most hindered by glasses or contacts? _____

- Please Circle any of these hobbies or activities that you participate in

Scuba Diving Kick boxing Karate Basketball Football Softball Sky Diving Racquetball Golf

Other: _____.

Signature: _____

Date ____ / ____ / ____