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 ______/______/______ CLCC22 4/11