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 ______/______/______

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