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__________________

- Do you visit an eye doctor on a regular basis? YES NO if yes, please list his/her name:____________________________

  When was your last eye exam? ____________________ Did your eye doctor discuss Laser Vision? 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 contacts you wear now or wore in the past.

Soft Toric RGP Multifocal Do you wear your contacts overnight? YES NO

- Do you do monovision with your contact lenses? YES NO Which eye is the reading eye: Right Left Unkown
- 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 ______/______/______

Amended 1/20