

Date: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, ST, Zip: \_\_\_\_\_  
 Gender \_\_\_\_\_ AGE \_\_\_\_\_  
 Referred By: \_\_\_\_\_

Employer: \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 Work Phone \_\_\_\_\_  
 Cell Phone \_\_\_\_\_

***For the most precise and accurate measurements, treatment, and results, please answer the following honestly.***

1. \* Hobbies: \_\_\_\_\_  
 \_\_\_\_\_ # of HRS on computer or desk work per day.

2. What is your most important reason for having laser vision correction?  
 \_\_\_\_\_

3. How important is the doctor's experience?  
 \_\_\_\_\_

4. Has another doctor ever evaluated you for laser vision correction? Y or N  
 Who? \_\_\_\_\_  
 Result? \_\_\_\_\_

5. Do your eyes feel dry or scratchy? Y or N .

6. Check any illness or health problems you have:  
 \_\_\_\_\_ Diabetes \_\_\_\_\_ Glaucoma \_\_\_\_\_ Heart disease  
 \_\_\_\_\_ Cancer \_\_\_\_\_ Asthma \_\_\_\_\_ Jaundice  
 \_\_\_\_\_ HIV \_\_\_\_\_ Hepatitis \_\_\_\_\_ Hypertension  
 \_\_\_\_\_ Depression/Anxiety  
 \_\_\_\_\_ **NONE OF THE ABOVE**

7. Is there a Family History of Glaucoma? Y or N

A. At what age did you start wearing glasses? \_\_\_\_\_  
 B. At what age did you start wearing contacts? \_\_\_\_\_

C. Do you see halos or glare? Y or N  
 D. Do you have trouble driving at night? Y or N

E. Is your vision in low light or at night  
 Same / Better / Worse than your daytime vision?

F. Name of your current eye doctor: \_\_\_\_\_

G. Are you planning on getting a pilot's license or  
 do you already have one? Y or N

8. List ALL current medications including tranquilizers, antidepressants or ANY TYPE OF EYE DROPS. \_\_\_\_\_

9. Are you Pregnant OR Breast Feeding? Y or N

10. Are you allergic to any medications or substance? Y or N  
 Please name them  
 \_\_\_\_\_

11. Do you smoke? Y or N If yes, how much?  
 \_\_\_\_\_

12. Please list any **EYE** injury, disease, or surgery (including color blindness). Name and date of diagnosis, and treating physician.  
 \_\_\_\_\_

13. Has your uncorrected distance vision always been good? Y or N.

14. Do You wear reading glasses or bifocals? Y or N or NA  
 Do you hate your reading glasses? Y or N.

Our goal is to provide you with the best functional vision. If you **had** to wear glasses **after Lasik** for one activity, for which activity would you be most willing to use glasses?

\_\_\_ Reading Fine Print / \_\_\_ Computer \_\_\_ Driving

H. Have you ever worn contact lenses? Y or N  
 I. If so, what type of contact lenses? Soft/ Gas Perm/Hard /Toric  
 J. Date contacts lenses last worn? \_\_\_\_\_  
 K. Have you stopped wearing your contacts? Y or N  
 Why \_\_\_\_\_  
 L. How long have you been wearing contacts? \_\_\_\_\_  
 M. Amount of time contact lenses worn per day? \_\_\_\_\_  
 N. Do you sleep in your contacts? Y or N  
 O. How do you like your vision with your contacts? \_\_\_\_\_  
 P. Have you worn monovision lenses? Y or N  
 Q. How did you like your Monovision with your contact lenses?  
 \_\_\_\_\_