REFRACTIVE SURGERY CONSULTATION FORM

(Circle one) LASIK CK

Name: ______________________________ **Date:** ______________

Address: ______________________________

City: ______________________________ **State:** __________ **Zip:** ___________

Home Phone No.: ___________ **Work Phone No.:** _____________ **Other (cell):** _____________

Emergency name/number: ________________ **Home Email Address:** ________________

Age: ______ **DOB:** __________ **Sex:** ________ **Occupation:** ______________________

Employer: ______________________________

Routine Optometrist/Ophthalmologist: ______________ **Family Physician** ______________

Medical Insurance: ______________________________

Do you wear Glasses? Yes (Distance Near Both) No **Contact Lenses?** Hard Soft GP Last Worn? ________

How did you hear about us? ______________________________

Newspaper (note which)________________ Patient referral (name)________________

Direct mail/flyer (note which)________________ Health Fair/Seminar (note which)________________

If you are a good candidate for Vision Correction, how soon would you like to have the procedure? __________

What has motivated you to consider Vision Correction? (Circle those that apply)

Improvement of job performance

Fire/Rescue Law Enforcement Medical Other______________________________

Increased enjoyment of sports

Water Sports Skiing Jogging/Hiking Exercise/Aerobics Racquet Sports

Golf Flying (Pilot) Baseball/Basketball/Football Other ______________________

The least I expect from Vision Correction is: (Circle all that apply)

See better using thinner glasses See without glasses for routine tasks

Pass a drivers test Meet job qualifications, which are: ______________________

Do you have any other objectives or expectations from having the procedure? ______________________

____

Do you have any challenges with your night vision while wearing your glasses or contacts? YES NO

Have you or do you intend to visit any other Laser Eye Centers or Doctors? YES NO

If yes, which: ______________________________

(Turn Over)

MEDICAL HISTORY

Please check YES or NO if you have any of the following conditions:	YES	NO
Diabetes	☐	☐
Pregnant/Nursing or planning on becoming pregnant in next 3 months	☐	☐
Rheumatoid Arthritis	☐	☐
Pacemaker	☐	☐
Psychiatric/Psychological Therapy/Depression	☐	☐
Drug Allergies	☐	☐
If yes, to what?____		
Have you ever taken Amiodarone (Cordarone, Pacerone)?	☐	☐
Have you taken Acutane (oral acne medication) within the last year?	☐	☐

If yes, when did you stop taking it? ____

Any other Existing Medical Problems:____

List Medications you are currently taking: ____

OCULAR HISTORY

Please check YES or NO if you have any of the following conditions:	YES	NO
Past or present problems with contacts	☐	☐
Ocular Infections? (Specifically Ocular Herpes)	☐	☐
Previous Eye Surgery	☐	☐
History of eye trauma	☐	☐
History of Kerataconus (Chronic Progressive Thinning of the Cornea)	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐
Retina Problems	☐	☐
Eye Muscle Problems or history or eye muscle surgery	☐	☐
Corneal erosion syndrome (from a prior corneal abrasion)	☐	☐
Have you been told you are not a candidate for Laser Eye Surgery	☐	☐

PREOPERATIVE EVALUATION

	YES	NO
Has your prescription changed significantly in the last year?	☐	☐
Are you over 40 years of age?	☐	☐
Have you had good vision all your life, until age 40?	☐	☐
Do you dislike wearing or dealing with glasses?	☐	☐
Do you remove your glasses to read?	☐	☐

DRY EYE CHECKLIST

Please check off any symptoms you have experienced with or without contact lenses.

____ Dry sensation
____ Stinging
____ Mucous discharge
____ Solution sensitivity
____ Light sensitivity
____ Lens discomfort
____ Scratchy, gritty feeling
____ Lid infections
____ Irritation from wind or smoke
____ Tired eyes
____ Excessive tearing
____ Eyelids stuck in a.m.
____ Burning
____ Soreness
____ Itching