NewView® EYE CENTER
See what you've been missing®

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