

Previous eye surgery or eye problems: _____

Have you ever been told you have cataracts? _____

Have you ever had cataract surgery? _____

Have you ever had LASER eye surgery? _____

Do you have any **family history** of eye disease? _____

Do you have any **family history** of any of the following (circle all that apply):

Glaucoma	Blepharitis	Diabetes	Stroke
Retinal Problems	Retinal Detachment	Thyroid Disease	Eye Exercises
Cataracts	Keratoconus	Rheumatoid Arthritis	Lupus
Lazy eye	History of crossed eye	Herpes of the Eye	Asthma
Eye patching	High Blood Pressure	Prism in Glasses	

Do you see an Optometrist or Ophthalmologist on a regular basis? Yes No
Who? _____

When was your last eye examination/ with whom? _____

Has your glasses/contact lens prescription changed in the last 2 years? Yes No

Do you wear a bifocal in your glasses for reading? Yes No

Have you ever had double vision in the past? Yes
No

Have you ever been prescribed *prisms* to wear in your glasses? Yes No

Are **you** currently experiencing any of these symptoms with your glasses or contacts or do you have difficulty with any of these tasks?

Check all that apply to **you**

<input type="checkbox"/> Blurred/fuzzy vision	<input type="checkbox"/> Difficulty seeing to read
<input type="checkbox"/> Double vision	<input type="checkbox"/> Difficulty seeing to drive
<input type="checkbox"/> Flashing lights	<input type="checkbox"/> Difficulty seeing street signs
<input type="checkbox"/> Eye Infections	<input type="checkbox"/> Problems with depth perception
<input type="checkbox"/> Eye Tearing/Discharge	<input type="checkbox"/> Glare
<input type="checkbox"/> Redness	<input type="checkbox"/> Night vision problems
<input type="checkbox"/> Cobwebs in vision	<input type="checkbox"/> Halos around lights
<input type="checkbox"/> Veil over vision	<input type="checkbox"/> Color vision problems
<input type="checkbox"/> Spots/Floaters in vision	

CONTACT LENS HISTORY:

Have you ever worn contact lenses? Yes No If yes, how many hours/day? _____

Do you wear lenses currently? Yes No What type? Rigid/Hard Soft Toric

When was the last time you used your contact lenses? _____

If you wore contact lenses in the past, why did you stop? _____

LIFESTYLE:

Occupation:

Have you had previous LASIK evaluations? Yes No

Activities/Sports/Hobbies: _____

What do you *expect* from refractive surgery?

For how long have you been considering refractive surgery? _____

How did you hear about us?

____ I am a patient in the practice

____ News article

____ Radio

____ Friend of patient in the office

____ Friend who has had refractive surgery

____ Newspaper ad

____ Telephone book

____ Other

If friend or doctor, please tell us who: _____

For technician and doctor comments below:

Comments:
