REFRACTIVE SURGERY PATIENT QUESTIONNAIRE

Name: _____ Date:_____

This information is strictly confidential. The answers will help determine if you are a suitable candidate. Certain health problems may indicate potential problems with healing.

MEDICAL HISTORY: Circle answer

1. Are you allergic to any medications? Y / N
   -If yes, please list: _____

2. Have you ever taken or are you currently taking Imitrex, Acutane, or Cordarone? Y / N

3. Do you take any medication on a regular basis, including birth control? Y / N
   -If yes, please list:_____

4. Are you pregnant or nursing? Y / N

5. Do you have a pacemaker? Y / N

6. Do you have any history of: (circle any that apply)
   - asthma/eczema - autoimmune disease
   - high blood pressure - heart problems
   - HIV/AIDS - diabetes
   - hepatitis - other: _____

EYE HISTORY

1. How old were you when you first started wearing glasses? _____

2. Any eye disorders? (circle any that apply)
   - glaucoma (high eye pressure) -dry eye syndrome - amblyopia
   - any eye injury - eye surgery - ALK/RK/LASIK/PRK
   - any eye infection - retinal tear/detachment - cataract
   - recurrent corneal erosion - keratoconus - herpes of the eye
   - any eye dystrophy or degeneration - other:_____

   If yes to any of the above, please explain:_____

CONTACT LENS HISTORY

1. In what year did you first start wearing contacts lenses? _____ What type? _____
2. What kind do you wear now? _____ How many hours a day? _____
3. When did you last wear your contacts? _____
4. Any history of contact lens related eye infections? Y / N Corneal ulcers? Y / N
5. Please check the type of contact lenses:
   - Soft Daily Wear - Soft Extended Wear - Hard Contacts
   - Soft Toric Lenses - Disposable Contacts - Rigid Gas Permeable

REASONS FOR WATING REFRACTIVE SURGERY: (Check all that are applicable)

- Job requirement - Can't wear contact lenses - Simply fed up
- Cosmetic (I hate my glasses) - Improved functional ability - Other
- Recreational activity (swimming, skiing, etc.) - Reduce dependence on glasses/contacts

1. What concerns do you have about having laser vision correction? _____
2. When would you be interested in having laser vision correction if you are considered a candidate?
   _____