Patient Questionnaire

Name____ acct#_______ Date___________

E-mail ____

How did you hear about us? Please mark one or more and give specific details.

- Newspaper ____
- Individual ____
- Radio/Television ____
- Letter/Mailed Offer ____
- Internet ____
- Yellow Pages ____
- Other ____

The following questions will help the doctor to determine any special visual needs.

Age: _____________ Occupation: ____

Hobbies: ____

Circle if you:

- ❖ Have been pregnant or breast feeding in the last 6 months
- ❖ Have ever had eye surgery or injury
- ❖ Have had a Herpes infection of the eye
- ❖ Form keloids (scar excessively)
- ❖ Have ever woken early in the morning with a painful or tearing eye
- ❖ Within last six months have taken Amiodarone, Accutane or Imitrex
- ❖ Have Diabetes, high blood pressure, heart disease, Lupus, Rheumatoid Arthritis or other connective tissue disorder
- ❖ Are HIV positive or have Hepatitis A,B or C

Eye History ____

Medical Problems ____

____

Current Medications ____

Drug Allergies ____

Do you wear soft or hard/rigid contact lenses? ____ No ____ Yes *(if yes, circle which)*

If yes, when was the last time you wore them? # _____ days, weeks, months, years *(circle one)*

How long have you worn corrective lenses? _____________________________________

Why do you desire vision correction surgery? ___________________________________

____

What questions do you have for us? ____

____

On a scale of 1-10, how interested are you in having your vision corrected? ____________

(1 = slightly; 5 = interested but need more information; 10 = ready to have procedure)

THANK YOU!