9-Mar-11

SIMON VISION INSTITUTE
GEORGE SIMON, MD

PATIENT REGISTRATION

Date:_____

Patient Information:

Name: First Mi Last **Birth Date:** Month/Day/Year **Age:** **Sex:** ☐ **M** ☐ **F**

Address: Street City State Zip

Home Phone: ( ) **Cell Phone: ( )**

Work Phone: ( ) **Email:**

Occupation: **Employer/Employer Address:**

Emergency Contact: **Phone: ( )**

Social Networking:

Have you visited our website at www.lasikcustomvision.com? ☐ Yes ☐ No

Have you visited our Facebook page? ☐ Yes ☐ No

Do you use Facebook? ☐ Yes ☐ No **How many Friends?**

Do you use Twitter? ☐ Yes ☐ No **How many followers do you have?**

Interest in LASIK:

How did you hear about us? ☐ Radio ☐ TV ☐ Internet Search ☐ Other - *please specify:*

☐ Referral - *what is their name?*

What activities/hobbies would you enjoy more without the dependency of glasses/contacts? (e.g. swimming, skiing, movies, reading, etc.) ?

What is your biggest concern about having LASIK?

How long have you been considering laser vision correction?

How many LASIK providers are you evaluating? ☐ One ☐ Two ☐ More than two ☐ Unsure

Will you use funds from an employer sponsored flexible spending plan to pay for this procedure? ☐ Yes ☐ No

If our schedule allows, would you be interested in having laser vision correction today? ☐ Yes ☐ No ☐ Maybe

Would you like Dr.Simon to call you prior to treatment to answer any questions? ☐ Yes ☐ No

RELEASE OF INFORMATION

I understand that this free consultation is for laser vision correction purposes only and is not a substitute for a routine eye exam. If I wish to have a copy of my exam records released to myself or another provider, I acknowledge that there may be a $150 charge to me, if permitted under state law.

_____ _____

Signature of Patient **Date**

Eye Health History:

When was your last eye exam? **Where or With Who?**

What type of vision problem are you currently experiencing?

☐ Decreased distance ☐ Decreased near ☐ Difficulty with night vision

Do you think your vision is stable? ☐ Yes ☐ No ☐ Unsure ***If stable, how long has it been stable?***

How are you currently managing your vision condition?

☐ **Glasses:** How old are your glasses?

☐ **Contacts:** ☐ Soft ☐ Toric ☐ Gas Permeable Do you sleep in your contacts? ☐ Yes ☐ No

How many years have you worn them? When did you last wear them?

Rate your satisfaction with your current glasses/contacts: ☐ Extremely Satisfied ☐ Very ☐ Somewhat ☐ Not Very ☐ Not at all

Have you experienced any of these eye issues within the last 6 months?

□ Dryness □ Sandy/Gritty Sensation □ Burning/Stinging □ Redness □ Tearing □ Itching □ Allergies

□ Trouble with night vision □ Glare □ Halos □ Light sensitivity □ Decreased contact lens wearing time

□ Occasional Blurred Vision □ Double Vision □ Eye Abrasion or Erosion □ Ocular Discomfort (aching)

Please list any eye drops you are presently using:

Have you or a family member (parent or sibling) ever been diagnosed with or treated for:

- Cataracts - □ Self □ Family
- Glaucoma - □ Self □ Family
- Strabismus (eye turn) - □ Self □ Family
- Diabetes - □ Self □ Family
- Retinal Disease - □ Self □ Family
- Amblyopia (lazy eye) - □ Self □ Family
- Blindness - □ Self □ Family
- Keratoconus - □ Self □ Family
- Other Corneal Disease - □ Self □ Family

Have you ever had any surgery, injury, or laser treatments to the eye? ☐ No ☐ Yes (please describe below)

Medical History:

Do you have or have you been treated for the following: (Check only those that apply)

□ Stroke
□ Seizure
□ Brain Tumors
□ Brain/Nerve Disorders
□ Asthma
□ Emphysema
□ Tuberculosis
□ Migraines
□ MS
□ Prostate Disease
□ Diabetes, *how long?* *Average blood sugar level:*
□ **Other *(please list)***

□ Ulcer
□ Stomach Disorders
□ Digestive Disease
□ Hepatitis B or C
□ Liver Disease
□ Kidney Stones
□ Kidney Infection
□ Nephritis
□ Pneumonia
□ HIV/AIDS

□ Heart Disease
□ Heart Attack
□ Bypass Surgery
□ Other Heart Disease
□ High Blood Pressure
□ Irregular Heart Rhythms
□ Thyroid Disease
□ Other Lung Disorders
□ Sleep Disorders
□ Inflammatory Bowel Disease

□ Currently Pregnant/Nursing
□ Rheumatoid Arthritis
□ Sarcoid
□ Lupus
□ Acne Rosacea
□ Autoimmune Disease
□ Keloids
□ Herpes Zoster (Shingles)
□ Psoriasis
□ Cancer or tumor, *type?*

List all MEDICATIONS that you are currently taking, including all over the counter meds:

□ None

List all medications that you are ALLERGIC to:

□ None

List all previous surgical procedures that you have had:

□ None

Thank you for taking the time to fill out our registration. Feel free to ask us any questions.