



Welcome to Herschel LASIK at Magruder Eye Institute

Today's Date: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First M.I.

Address: \_\_\_\_\_  
Street Address Apartment/Unit #  
City State Zip Code

Home Phone: ( ) \_\_\_\_\_ Business Phone: ( ) \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_

What is the best way to contact you?  Cell Phone  Home Phone  Email  Text

How did you hear about us?  Radio  Newsletter  Billboard  Health Fair  Friend

TV  Newspaper  Direct Mail  Internet  Other \_\_\_\_\_

BRIEF HISTORY AND QUESTIONNAIRE

My main visual problem (check all that apply):

- Fine Print
- Near Vision
- Intermediate/Computer
- Distance Vision
- Night Driving

My current prescription is for (check all that apply):

- Myopia or nearsightedness
- Hyperopia or farsightedness
- Astigmatism
- Presbyopia (I wear bifocals or glasses for reading)
- Unsure at this time

Do you currently wear (check all that apply):

- Glasses for Distance
- Progressive Glasses
- Bifocal or reading glasses
- 1-2 week Disposable Contact Lenses
- Monthly Disposable Contact Lenses
- Daily Contact Lenses
- Extended Wear Contact Lenses
- Toric Contact Lenses
- Trial Contact Lenses
- Monovision Contact Lenses
- RGP/Hard Contacts
- Other \_\_\_\_\_

Do you have a history of any of the following (check all that apply):

- Keratoconus
- Diabetes
- High Blood Pressure
- Thyroid Condition
- Glaucoma
- Keloid Former
- Past Eye Conditions \_\_\_\_\_
- Former Surgeries \_\_\_\_\_

When was your last eye exam? \_\_\_\_\_

Do you have an optometrist/ophthalmologist you see on a regular basis? \_\_\_\_\_

**FOR WOMEN ONLY:**

Are you currently pregnant?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Are you currently breast feeding?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you recently discontinued breast feeding?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<i>If yes</i> , how long ago did you Stop?	_____	

	Yes	No
Is this your first vision correction consultation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you know any friends or family members who have had the LASIK procedure?	<input type="checkbox"/>	<input type="checkbox"/>
Do your glasses or contacts interfere with your recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>
If you lost or misplaced your glasses or contacts, would you be able to function throughout the day?	<input type="checkbox"/>	<input type="checkbox"/>
If you could function throughout your day without dependence on contacts or glasses, would you consider the procedure a success?	<input type="checkbox"/>	<input type="checkbox"/>
Are you interested in learning about our various payment option programs?	<input type="checkbox"/>	<input type="checkbox"/>

What is it about your glasses or contact lenses that currently prevent you from enjoying everyday living?

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How long have you been considering the LASIK procedure? \_\_\_\_\_

Do you have any specific fears regarding vision correction?

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Is there anything preventing you from proceeding with the LASIK procedure prior to your visit other than financial arrangements?

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When do you plan on having LASIK ? \_\_\_\_\_

***For Office Use Only***

Notes: