HERSCHEL LASIK

***Welcome** to Herschel LASIK*

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 _____
- ☐ Dry Eye _____
- ☐ 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? ☐ YES ☐ NO Are you currently breast feeding? ☐ YES ☐ NO

Have you recently discontinued breast feeding? ☐ YES ☐ NO ***If yes***, how long ago did you Stop? _____

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

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

_____

_____

How long have you been considering the LASIK procedure? _____

Do you have any specific fears regarding vision correction?

_____

_____

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

_____

When do you plan on having LASIK ? _____

For Office Use Only

Notes: