Tylock Eye Care & Laser Center
Patient History Information

Name_____
Date_____

1) Any eye trauma/injury? Y or N
If so, please explain_____

2) Any major eye infections? Y or N
(including ulcers and recurrent corneal erosion)
If so, please explain_____

3) Any prior eye surgery of any kind? Y or N
(including RK, PRK, LK and LASIK)
If so, please provide approx. date_____

4) Date of last eye exam _____

5) Contact lens wear? Y or N Soft or Hard
Date lenses removed _____

6) Any dryness? Never Occasionally Often Always

7) Night vision - please circle all that apply:

Ghosting Glare Halos Starbursts

8) Age _____

9) Occupation _____

10) Any comments/concerns?
_____
_____
_____
_____