DEMOGRAPHICS

Full Name____ Preferred "Nickname"__________________

(last) (first) (middle)

Mailing Address____ City/St/Zip___________________________

Home Phone______________________Work Phone___________________Cell Phone_____________________

Email____ Male/Female_____ DOB_______________

Employer____ Occupation__________________________

Insurance (primary)______________________________Insurance (secondary) ____________________________

Spouse____

OCULAR HISTORY

How often do you wear eyeglasses or contact lenses for distance vision? ☐ Not at all ☐ Part-time ☐ Full-time

Do you need eyeglasses for reading? ☐ Yes ☐ No

Do you currently wear contact lenses? ☐ Yes ☐ No

What kind of contact lenses do you wear now? ☐ Soft ☐ Rigid gas permeable ☐ Hard

How long have your contacts been out? ____________________________________

Have you tried monovision with contacts (one eye for distance vision, the other eye for reading)? ☐ Yes ☐ No

If so, was it successful for you? ☐ Yes ☐ No

List all eye surgeries you have had. Indicate which eye and the date of surgery:___________________________________

____

List any eye injuries with dates:____

List any eye diseases you have/had:____

List any eye drops you use. Indicate which eye and how often:____

Do you currently experience glare/halos around lights at night or have other night vision problems? Please explain.________

____

MEDICAL HISTORY

List all other surgeries you have had, with dates:____

List any medications that you are allergic to:____

List all medications you currently take. Include dosage and frequency:____

____

Do you or anyone in your immediate family now have or have had any past history of the following conditions?

	You	Family		You	Family
Atopic disease	☐	☐	Rheumatoid arthritis	☐	☐
Autoimmune disease	☐	☐	HIV infection	☐	☐
Diabetes	☐	☐	Keloid formation	☐	☐
Hepatitis	☐	☐	Glaucoma	☐	☐
Acne	☐	☐	Cataracts	☐	☐
Retinal disease	☐	☐	Mental illness / depression	☐	☐

Other medical problems (please list)____

If male, have you been diagnosed with BPH (benign prostatic hyperplasia) or prostate disease? ☐ Yes ☐ No

Do you take (or have you ever taken) Flomax® or other medication for BPH or other prostate disease? ☐ Yes ☐ No

If medication other than Flomax®, list name: ____

If female, are you or might you be pregnant? ☐ Yes ☐ No Are you trying to become pregnant? ☐ Yes ☐ No

Are you currently breastfeeding? ☐ Yes ☐ No

GENERAL

How did you hear about our practice / doctor?____

What hobbies/activities do you participate in frequently?____

Who are your current doctors?

Eye Doctor____ Phone__________________________________

General Doctor____ Phone__________________________________

If you are considering elective vision correction surgery (i.e. LASIK), please answer the following questions:

What is your main reason (motivation) for considering LASIK?____

If LASIK is not recommended by our surgeon, would you be open to considering alternative procedures?_______________

If it is determined that you are a candidate for LASIK (or an alternative procedure), what is the most important factor in your decision?

☐ surgeon experience ☐ affordability ☐ technology ☐ other__________________________

How will having LASIK have an effect on your life / lifestyle?____

____

Patient Signature____ Date_________________________________