LASIK Checklist

NAME _____

YES	NO	Without glasses or contact lenses….
☐	☐	Do you have trouble seeing at distance?
☐	☐	Do you have trouble seeing up close?
☐	☐	Do you have night vision problems?
		Describe: _____
☐	☐	Do you have dry eye problems?
		When: _____
☐	☐	Are you pregnant or nursing?
☐	☐	Do you have severe diabetes or severe allergies?
☐	☐	Do you have any active eye diseases, for example glaucoma or cataracts?
☐	☐	Do you have collagen vascular, autoimmune or immunodeficiency diseases (for example: Rheumatoid arthritis, Lupus, AIDS)?
☐	☐	Do you show signs of keratoconus (corneal disease)?
☐	☐	Would you be satisfied if your natural vision was greatly improved even if you still had to wear glasses some of the time?
☐	☐	Do your glasses or contacts interfere with your recreational activities?
		If yes, which activities: _____
☐	☐	Do you feel that good vision without glasses is more important to you than perfect vision with glasses?
☐	☐	Is it acceptable to you that you may need glasses for reading after LASIK?
☐	☐	Do you have vision problems with reading or computer work?
		If yes, please describe: _____
☐	☐	Does your work or profession put vision restrictions on your employment? If yes, please describe:
		_____

PATIENT HISTORY

REFERRING DOCTOR: _____

CONTACT INFORMATION

First Name:	Last Name:	DOB:	Gender: M F
Address:	City:	State:	Zip:

Phone:	E-mail:	Occupation:
Emergency Contact:		Emergency Phone:
Preferred Pharmacy:		

MEDICAL HISTORY

Do you have allergies? If yes, explain:
List <u>all</u> medications you take (including over the counter) or provide us a list:
Are you currently being treated for <u>any</u> medical condition? If yes, please explain:

FAMILY HISTORY

Is there a family history of eye disease? If yes, explain:					
Do you smoke? If yes, how much:			Do you drink? If yes, how much:		
Have you ever had or been told that you have?	**Yes**	**No**		**Yes**	**No**
Glaucoma			Diabetes		
Cataracts			High Blood Pressure		
Retinal Detachment/Disease			Heart Disease		
Lazy Eye/Amblyopia			Breathing Problems		
Eye Surgery			Auto-Immune Disease		
Dry Eye			Arthritis		
Eye Injury/Infection			Seasonal Allergies		
Other (list):					

EYE HISTORY

When was your last exam?	Doctors Name/City:	
How old are your current glasses?	Do you wear contacts? Yes	How old are your contacts?
How often do you use glasses?	Never Constantly Reading Only Distance Only Rarely	

SIGNATURE: _____ **DATE:** _____