



PATIENT INFORMATION SHEET

The following questions will help in determining what kind of candidate you will be for laser vision correction.

Name _____ Date _____

Email Address _____

Sports/Hobbies/Interests _____

Profession _____

How were you referred to this practice? ___ Newspaper ___ Radio ___ Internet ___ Phone Book
___ Mailer ___ Doctor ___ Other (*Name Radio Station/Newspaper/Doctor) _____
___ Friend/Relative/Co-Worker (Name) _____

Date of last eye exam _____ How old are your current eyeglasses? _____

Current Eye Care Doctor _____

Has your prescription been stable for two years? Y or N

Do you wear glasses: ___ Full time ___ Part time ___ Very little ___ Never

Do you wear contacts: ___ Full time ___ Part time ___ Very little ___ Never

What type of contact lenses do you wear: ___ Soft ___ Soft Torics ___ Gas Perm (RGP) ___ Hard

Date that you last wore your contact lenses _____ Number of years worn _____

Please check those that apply to you:

Medical History

___ Pregnant or nursing within the past 6 months

___ Diabetes—type _____

___ Sjogrens Syndrome

___ Rheumatoid Arthritis

___ Lupus

___ Crohn's Disease

___ Keloids

___ Rosacea

___ Pacemaker/Defibrillator

Ocular History

___ Cataracts

___ Retinal Disorders

___ Dry Eyes

___ Refractive Surgery

___ Glaucoma

___ Corneal Disease

___ Corneal Scars

___ Eye Condition/Injury/Surgery

List any drug allergies: _____

List any medications you currently take: _____

What problems are you having with your current system of vision correction? _____

***I understand this is a refractive screening only and does not replace a full eye exam by an ophthalmologist or optometrist. This screening is educational only and does not fulfill the requirements of a diagnosis or treatment.

Patient _____ Date _____