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Thank you for taking the time to complete this questionnaire prior to your appointment. The information it contains will be kept in strict confidence. Please **print** all items **clearly**.

Name: ______________________________ Age: ________ Sex: male female

Date of Birth (mm/dd/yy):_______________ Occupation: _________________________

Referring Doctor

Name: ______________________________ Phone: (____)_____________________

Address: ____

Why are you interested in vision correction procedures? (Check all that apply)

☐ I dislike wearing eyeglasses.

☐ I dislike my appearance with eyeglasses.

☐ Contact lenses are irritating or uncomfortable.

☐ Contact lenses are inconvenient.

☐ I want freedom from dependency on artificial devices.

☐ Eyeglasses and contacts are inconvenient for sports and recreation.

☐ I hope to undertake a career that requires good vision (police, fire, etc.)

☐ I am concerned about functioning in an emergency.

☐ Other reasons: ____

Activities and Hobbies: ____

Glasses History

How often do you wear eyeglasses or contact lenses for distance vision?

☐ full time ☐ part time ☐ not at all

Do you need eyeglasses for reading? ☐ yes ☐ no

Contact Lens History

Do you currently wear contact lenses? ☐ yes ☐ no

What kind of contact lenses do you wear now? ☐ soft ☐ 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

OVER

Past Medical History

List all previous surgery, including eye surgery, with dates: ______________________

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List all non-surgical (medical) hospitalizations with dates: ______________________

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Circle any of the following problems that apply to you:

asthma	diabetes	hypertension	migraines
bronchitis	emphysema	infections	neurologic disorders
cancer	heart disease	kidney disease	thyroid problems

Other Problems: ____

Allergies (to medicine): ____

List the **medicines** you currently take (pills and eyedrops):

Medicine	**Strength** mg or % you take each time	**Dosage** how many pills/drops each time	**Frequency** how many times per day?	**Start**

Room for additional comments:

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