Refractive Surgery Patient Questionaire

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(To be filled out by the patient)

Name _____ Date of birth _____

Age_____ Age glasses first worn_____

Date glasses last changed _____

Occupation_____

THE FOLLOWING INFORMATION WILL HELP US MAKE A PRELIMINARY DETERMINATION OF YOUR ELIGIBILITY FOR SURGERY.

Do you wear glasses for distance vision only _____Distance and near_____
Do you wear bifocals? No Yes If YES, For how long? _____
Have you ever worn contact lenses? No Yes What type? Hard Soft

If you have worn contact lenses, what problems have you had? (Please check those that apply.)

Discomfort _____ Vision not as good at night _____
Glare _____ Frequent irritation _____
Intolerance to lenses _____ Eyes dry or burn _____
Recurrent abrasions of cornea _____ Other _____

What problems have you had with glasses? (Please check those that apply.)

Side vision blocked _____ Uncomfortable _____
Hard to adjust _____ Interference with sports _____
Hard to keep clean _____ Other _____

Allergies to medication? No Yes Please list:_____
On birth control pills or any medications? No Yes
For what conditions? _____
Any history of eye injury? No Yes Any eye infections? No Yes

Have you ever been diagnosed with any of the following?

Corneal inflammatory disease	No	Yes	History of Herpes Keratitis	No	Yes
Diagnosed Autoimmune disease	No	Yes	Keratoconus	No	Yes
Recurrent / Active external disease	No	Yes	Active external ocular infections	No	Yes
Diabetes Mellitus	No	Yes	Grossly irregular astigmatism	No	Yes
Cataracts	No	Yes	Glaucoma	No	Yes

Other ? _____

Why are you interested in refractive surgery?

Signature ______________________________________ **Date**____________________