LASIK CONSULTATION INFORMATION

Name: _____ DOB: _____ Age: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Phone: ( )_____ ( )_____
Home Business

Cell: ( )_____ email: _____

May we contact you in the future via mail and/or email? Y N Initials: _____

Emergency Contact: _____
Name Relation Phone

Medical History: (Please circle all that apply)

Glaucoma	Blepharitis	Diabetes
Retinal problems	Recurrent red eyes	Thyroid Disease
Cataracts	Dry Eyes	Arthritis
Lazy Eye	Ocular Herpes infection	Keloid Former
Pregnant/Nursing		

Other: _____

Current Medications: _____

Allergies to medications: _____

Previous Eye surgery or eye problems: _____

Do you see an Ophthalmologist or Optometrist on a regular basis: Yes No

When was your last eye exam? _____

Corrective Lens History

Do you wear contact lenses? Yes No If yes, how many hours per day? _____

Are your contacts: RGP/Hard Soft Do you sleep in your contacts? Yes No

If you wore contacts in the past and stopped, why? _____

Lifestyle

Occupation: _____ Have you had previous LASIK consults? ____

What are your goals in having LASIK? _____

How did you hear about us? _____