

Patient Questionnaire

Name _____ Ivy# _____ Date _____

E-mail _____

How did you hear about us? Please mark one or more and give specific details.

- Newspaper _____
- Individual _____
- Radio/Television _____
- Letter/Mailed Offer _____
- Internet _____
- Yellow Pages _____
- Other _____

The following questions will help the doctor to determine any special visual needs.

Age: _____ Occupation: _____

Hobbies: _____

Circle if you:

- | | |
|---|--|
| ❖ are pregnant or breast feeding | ❖ within last six months have taken Amiodarone, Accutane or Imitrex |
| ❖ have ever had eye surgery or injury | ❖ have Diabetes, high blood pressure, heart disease, Lupus, Rheumatoid Arthritis or other connective tissue disorder |
| ❖ have had a Herpes infection of the eye | |
| ❖ form keloids (scar excessively) | |
| ❖ have ever woke early in the morning with a painful or tearing eye | |

Eye History _____

Medical Problems _____

Current Medications _____

Drug Allergies _____

Do you wear soft or hard/rigid contact lenses? _____ No _____ Yes (*if yes, circle which*)

If yes, when was the last time you wore them? # _____ days, weeks, months, years (*circle one*)

How long have you worn corrective lenses? _____

Why do you desire vision correction surgery? _____

What questions do you have for us? _____

On a scale of 1-10, how interested are you in having your vision corrected? _____

(1 = slightly; 5 = interested but need more information; 10 = ready to have procedure)

THANK YOU!