OMNI EYE CENTER LASERVISION

Patient Questionnaire

Name_____ 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: _____

Check if you:

- ☐ Have been pregnant or breast feeding in the last 6 months
- ☐ Have ever had eye surgery or injury
- ☐ Have had a Herpes infection of the eye
- ☐ Form keloids (scar excessively)
- ☐ Have ever woken early in the morning with a painful or tearing eye
- ☐ Within last six months have taken Amiodarone, Accutane or Imitrex
- ☐ Have Diabetes, high blood pressure, heart disease, Lupus, Rheumatoid Arthritis or other connective tissue disorder
- ☐ Are HIV positive or have Hepatitis A,B or C

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!