

SCREENING QUESTIONNAIRE

Patient Name (Last, First, M.I): _____ **Rank:** _____ **SS#** (Last 4): _____

List your hobbies or activities that require special visual needs (Example: skiing, woodworking, computers, sports, ect.):

In your own words, please list what your expectations from eye surgery are:

How long have you worn glasses? _____ years, since age _____

Do you wear contact lenses? Y / N If yes, for how long? _____ years/months, ___hours per day, last worn _____

What Type? (Circle): Rigid gas perm Soft Daily Extended Disposable Occasional

Do you have, or have you ever had any of the following eye conditions:

Corneal Diseases Y / N Keratoconus Y / N Glaucoma Y / N Herpes Keratitis Y / N Elevated eye pressure Y / N
Amblyopia / Lazy eye Y / N Eye Surgery / Laser Y / N Cataract Y / N Retinal Problems Y / N Prism in eyeglasses Y / N

Other eye problem or dates of eye surgery:

Family History: Keratoconus Y / N Glaucoma Y / N Other eye problems: _____

Do you have or have you been treated for the following medical problems?

Y / N Connective tissue disease, autoimmune disease, immuno-deficiency (e.g. Rheumatoid Arthritis, Lupus, Sarcoid, HIV)?

Y / N Diabetes ? If so, for how long and what type? _____

Y / N Smallpox vaccination in the last 3 months? If yes include the date.

Y / N Formed keloids ? (e.g. heavy scarring over cuts, stitches or surgical incisions)?

Y / N Taking any of these medications?: Accutane (isoretinoin) for acne, or Cordarone (amiodarone hydrochloride) for controlling irregular heartbeat, or Imitrex (sumatriptan) for migraine headaches?

Y / N / NA For women, Have you been pregnant or nursing within the last 3 months?

Other health problems: _____

List all medications you take regularly including over-the-counter medications and vitamins:

Are you allergic to any medications? Yes / No (please list and include any shellfish, iodine, and latex allergy):

Laser vision correction questions:

1.) I understand that laser vision correction may not correct all of my myopia, hyperopia, and or astigmatism and that I may still need to wear glasses or contact lenses after laser surgery for the best correction of my vision. _____ (patient initials)

2.) I understand there is a chance I cannot be fit with contact lenses after laser vision correction. _____ (patient initials)

3.) I understand that reading glasses may be needed after laser vision correction, even if not needed now. _____ (patients initials)

Any recent hospitalizations or overnight stays at the hospital ? Y / N If yes, for how long? _____

Is your spouse (or someone who lives with you) a healthcare worker ? Y / N If yes, for how long? _____

Please circle the response that best describes your current symptoms. (before surgery)

Pre-op Symptoms	Right Eye	Left Eye
Dry Eyes	0 = none 1 = minimal 2 = mild 3 = moderate 4 = severe	0 = none 1 = minimal 2 = mild 3 = moderate 4 = severe
Glare / Haloes	0 = none 1 = minimal 2 = mild 3 = moderate 4 = severe	0 = none 1 = minimal 2 = mild 3 = moderate 4 = severe
Quality of daytime vision with current lenses	0 = excellent 1 = very good 2 = good 3 = fair 4 = poor	0 = excellent 1 = very good 2 = good 3 = fair 4 = poor
Quality of nighttime vision with current lenses	0 = excellent 1 = very good 2 = good 3 = fair 4 = poor	0 = excellent 1 = very good 2 = good 3 = fair 4 = poor
Overall satisfaction with your current lenses	0 = very satisfied 1 = somewhat satisfied 2 = satisfied 3 = mildly dissatisfied 4 = very dissatisfied	0 = very satisfied 1 = somewhat satisfied 2 = satisfied 3 = mildly dissatisfied 4 = very dissatisfied

Patient statement: "I certify that the above information is complete and correct to the best of my knowledge." (Signed) _____

Revised 14 Nov. 2010 / Refractive Surgery

Physician Signature _____