REFRACTIVE EVALUATION HEALTH HISTORY

Patient Name **Age** **Date** **Chart Number**

Patients most satisfied with the results of refractive eye surgery understand the criteria for eligibility, possess realistic expectations and clearly understand the potential risks and side effects associated with surgery.

What procedure are you interested in? _____

What is your occupation? _____

Do you wear glasses? _____ **Yes** _____ **No** **Distance, Reading or Both?** _____

Do you wear contact lenses? _____ **Yes** _____ **No** **Hard, Soft, Toric?** _____

Last day / date contacts were worn: _____

What is your reason for considering refractive surgery? _____

When are you interested in having refractive surgery? _____

	Yes	No
Has your lens prescription changed within the last year?		
Are you pregnant / nursing or do you expect to become pregnant within 6 months following surgery?		
Have you had refractive surgery in the past? (RK; PRK; LASIK)		
Do you have unstable or uncontrolled diabetes?		
Do you suffer from an autoimmune disease?		
Do you take medications or undergo therapy that suppresses your immune system?		
Have you been diagnosed with an uncontrolled vascular disease?		
Do you have medical problems related to your eyes, such as keratoconus or glaucoma?		
Do you take hormone replacement medication?		
Do you have a history of excessive scarring with injuries or after surgeries?		
Do you suffer from chronic herpes infections or connective tissue disorders?		
Do you suffer from rheumatoid arthritis?		
Do you have dry eyes?		
Do you suffer from lupus?		
Have you ever used monovision contact lenses? (One eye focused at distance, the other at near)		
Do you experience glare at night from oncoming headlights?		
Do your glasses or contact lenses interfere with your job, sports or daily activities?		
Do you clearly understand that the effects of LASIK/CLEAR are permanent and do not wear off?		
Do you understand that you may need to wear reading and/or computer glasses after surgery?		
Do you have any medication allergies? If yes, please list them :		
Are you sensitive to latex?		

Patient Signature: _____ **SX Initials:** _____