Davis Vision Center

LASIK Patient Information Sheet

Last Name:_____ First Name:_____ M.I._____
Address:_____ City:_____ State:_____ Zip:_____
Age:_____ Birthdate:_____
Telephone (Home): (___)_____ Gender: ☐ Female ☐ Male
Telephone (Cell): (___)_____ Occupation:_____
Telephone (Work): (___)_____ Email:_____
Emergency Contact: (___)_____ Name:_____ Relation:_____

If you wear contacts please answer the following:
Type of contact lenses: ☐ Soft daily wear ☐ Soft extended wear ☐ Toric ☐ Gas Permeable
What are your reasons for considering refractive surgery?
☐ Freedom from glasses and/or contact lenses ☐ Intolerance to contact lenses ☐ Sports
☐ Occupational ☐ Other_____

Has your prescription been stable for the past year? ☐ Yes ☐ No
Do you have any eye problems other than corrective lenses? ☐ Frequent Red Eyes or Infection
☐ None ☐ Keratoconus ☐ Injury/Scar ☐ Retina ☐ Glaucoma ☐ Cataract ☐ Prism in Glasses
☐ Amblyopia (lazy eye) ☐ Dry Eyes ☐ Recurrent corneal erosion ☐ Herpes of the eye
Have you had previous Eye Surgery? ☐ Yes ☐ No
Explain:_____

Do you have any allergies or sensitivities to any of the following? ☐ Steroids ☐ Betadine ☐ Latex ☐ Adhesive tape ☐ Other_____

Do you have or have you ever had:			Are you presently taking:					
Tuberculosis	yes	no	Antibiotics	yes	no	Cordarone	yes	no
Diabetes	yes	no	Anti-Coagulants	yes	no	Tranquilizer	yes	no
Hepatitis B	yes	no	Blood Pressure Meds.	yes	no	Imitrex	yes	no
Hepatitis C	yes	no	Heart Medication	yes	no	Accutane	yes	no
Auto Immune Disease	yes	no	Insulin	yes	no	Anti anxiety meds	yes	no
(e.g. Rheumatoid Arthritis, Lupus)			Contraceptives	yes	no			
HIV/AIDS	yes	no	Aspirin (ASA)	yes	no			
Keloid Scarring	yes	no	Anti-Depressants	yes	no			
A Pacemaker	yes	no	Steroids	yes	no			
Other:_____			Sulfa Drugs	yes	no			

Please read the following and initial beside each line to indicate that you have read them. Please feel free to ask your surgical counselor if you have any questions.

_____ Refractive Surgery is not recommended if you are pregnant, plan to become pregnant in the next two months, or are nursing.
_____ You will not be able to drive home after your surgery. Please arrange for transportation.
_____ Refractive surgery is not 100% predictable; further treatment may be required.
_____ Most people require glasses for near-vision tasks beginning in their early 40's; refractive surgery will not prevent this.
_____ The pre-op appointment is approximately 2 hours in length, and the surgery appointment is approximately 1 ½ hours in length.

On a scale of 1-10 how fearful are you of having Lasik surgery? _____
On a scale of 1-10 how important is cost? _____
Have you ever looked into having Lasik before, and if so why didn't you have it then? _____
_____
What is your main concern with Lasik vision correction? _____

_____ How did you hear about Davis Vision Center? _____
Patient's Signature Date