REFRACTIVE SURGERY QUESTIONAIRE

Date_____
Name_____
Date of Birth(MM/DD/YY)_____/_____/_____ Age _____
Education_____ Job title _____Company_____
Race: [White___ Hispanic __ AfricanAmerican__ Other_____]
Country of origin_____
Which language do you prefer to be addressed in?: English____ Spanish ____
Home Address: _____
City_____ State_____ Zip Code _____
Home Phone ( )_____Work Phone ( )_____
Other ( )_____
Do you have access to internet? Yes___ No___ e-mail address:_____
Have you seen the Laser Eye Center of Miami's Web site? Yes___ No___

Referred by:
Former patient (Name)_____
Radio (Station)_____
Newspaper/Magazine_____
Internet_____
Other_____

List your hobbies or activities that require special visual needs:
1._____ 3._____
2._____ 4._____

Please describe in your own words what your expectations are with refractive surgery.
1._____
2._____

How long have you worn glasses? _____
How long have you worn contact lenses? _____
Contact lens type: PMMA (Hard) _____ RGP(Gas Permeable)_____
Soft: Daily wear_____ Extended Wear_____
How many hours do you wear them daily?: _____
Contact lens prescription if known: OD_____ OS_____

Name of Optometrist/Optical:_____ Phone Number:_____

Are you pregnant or nursing at this moment? Yes____ No_____

Please list all the medications that you are currently taking._____
_____
Are you taking Amiodarone? Yes ___ No___ Retin-A? Yes____ No____

Are you allergic to any medications? _____

Circle if you have had any of the following:
Keratoconus Herpes simplex Eye surgery Eye trauma Glaucoma Dry eyes
Comments_____
_____