REFERRAL SOURCE: ______________________________

NAME: ______________________________ **DOB:** ______________

Your Occupation: ______________________________ Your Age: ______________

Height: ______________ Weight: ______________ Do you smoke? YES or NO

Have you ever smoked? ______________ Quit Date: ______________

How long ago was your last cigarette? ______________ How many cigarettes a day? ______________

List your hobbies and any activities that require special visual needs: (i.e. flying, reading music, golf, sewing, swimming, etc.)

1. ______________ 2. ______________ 3. ______________

4. ______________ 5. ______________ 6. ______________

List all medical conditions you are being treated or followed for: (i.e. high blood pressure, heart conditions, arthritis, diabetes, lupus, etc.) –

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List any allergies you have: ______________________________

Have you ever had any of the following conditions? Please circle yes or no.

Amblyopia (Lazy eye)	YES NO	Autoimmune Disease	YES NO
Corneal Disease	YES NO	Diabetes	YES NO
Cataract	YES NO	Cold Sores/shingles on/around eye	YES NO
Dry Eye	YES NO	Immunosupressed/compromised	YES NO
Glaucoma	YES NO	Keloid formations	YES NO
Ocular Trauma	YES NO	Keratoconus	YES NO
Previous eye surgery/lasers	YES NO	Pregnant or nursing currently	YES NO
Progressive Myopia	YES NO	Uncontrolled vascular disease	YES NO
Retinal Problems	YES NO	Other:	YES NO

Do you wear contact lenses? YES NO

How long have you worn contacts lenses? ______________________________

What type do you wear? PMMA (Hard) RGP (gas permeable) SOFT TORIC

How do you wear them? Daily Wear Extended Wear Disposable

Have you discontinued contact lens wear? If so, why? ______________________________

When did you last wear your contact lenses? ______________ Hours / days / weeks / months ago

How did you hear about us? ______________________________

In your own words, please describe your expectations for surgery.
Example: To be able to wake up and see the alarm clock, to function in an emergency, to pass vision requirements for the police/fire departments.

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Patient initials: ______________ Technician initials: ______________ DATE: ______________