

Howerton Eye Center

LASIK Questionnaire

Patient's Name: _____ Date: _____

For the most precise and accurate measurements, treatment and results, please answer the following honestly:

1. What is your most important reason for having laser vision correction? _____

2. Why did you choose the Howerton Eye Center? _____

3. Women: Are you pregnant? Yes/No Breast Feeding? Yes/No

4. List all current medications including tranquilizers, anti-depressants, birth control

5. Do you have any allergies to medications or other substances? Yes/No
Names of medications: _____

6. Do you smoke? Yes/No If yes, how much? _____

7. Have you had any eye injuries or surgeries? If yes, please explain

8. Do you wear contact lenses? Please circle: Soft/Disposable Gas Permeable Toric

9. When was the last day contacts touched your eye? _____

10. How long have you been wearing contacts? _____

11. Do you use reading glasses? Yes/No

12. **Circle** any past or present illness: diabetes glaucoma TB cancer heart disease asthma stomach ulcers kidney disease hepatitis rheumatic fever pneumonia bleeding tendencies depression/anxiety hypertension sexually transmitted diseases alcoholism drug abuse HIV NONE OF THE ABOVE