The Cornea & Laser Eye Institute, P.A.

PATIENT QUESTIONNAIRE

DATE_____

NAME_____ _____
(LAST) (FIRST)

OCCUPATION_____

ACTIVITIES & HOBBIES_____

DEMOGRAPHICS

- ☐ **African American**
- ☐ **Asian**
- ☐ **Caucasian**
- ☐ **Hispanic**
- ☐ **Other (please specify)** _____

OCULAR HISTORY (Please mark an X in the appropriate box)

1. **Do you wear eyeglasses, contact lenses or both?**
   - ☐ **Glasses**
   - ☐ **Contact Lenses**
   - ☐ **Both**
2. **Have you ever worn contact lenses?** ☐ **Yes** ☐ **No**
3. **What type of contact lenses do you currently wear?** ☐ **Soft** ☐ **Rigid** ☐ **Hybrid**
4. **How long have you worn contact lenses?** ☐ **Months** ☐ **Years**

	Yes	No	List Here
5. Do you use any eyedrops?			
6. Do you rub your eyes?			
7. Have you had any previous eye surgery?			**List Here – include date**

GENERAL MEDICAL HISTORY (please mark an X in the appropriate box)

8. Do you have any of the following eye conditions?

	Yes	No	Please specify
Cataract			
Corneal ectasia			
Corneal dystrophies			
Glaucoma			
Keratoconus			
Macular degeneration			
Retinal detachment			
Other, specify			

Do you now or did you in the past have any of the following conditions?

	Yes	No	Please specify
Allergies (medications)			
Allergies (other)			
Arthritis			
Asthma			
Cardiac (heart) disorders			
Collagen vascular diseases (ex. Rheumatoid Arthritis)			
Diabetes			
Hepatitis			
History of keloid formation			
HIV			
Hypertension			
Lupus (SLE)			
Seizure disorders			
Thyroid disorders			
Other			

If FEMALE, please complete the following 2 items:

	YES	NO	
Currently pregnant			
Currently nursing			

9. Do you take any of the following medications?

	Yes	No	Please Specify	Start Date
Antibiotics (for infection)				
Anticoagulants (to thin blood)				
Antidepressants				
Aspirin				
Blood pressure medications				
Corticosteroids				
Imitrex				
Insulin				
NSAIDS (Motrin, Advil, etc.)				
Retin-A				
Other, please specify				

FAMILY MEDICAL HISTORY (Please mark an X in the appropriate box)

9. Has any close family member had any of the following conditions?

	Yes	N	Please Specify
Cataract			
Corneal dystrophies			
Collagen vascular disease			
Diabetes			
Ectasia			
Glaucoma			
Keratoconus			
Macular degeneration			
Retinal detachment			
Other, please specify			

To the best of my knowledge, the proceeding information is complete and correct.

_____ **Date** ☐☐ month ☐☐ day ☐☐ year

Patient signature