The Cornea & Laser Eye Institute, P.A.

PATIENT QUESTIONNAIRE

DATE____________

NAME________________________ ________________________
(LAST) (FIRST)

REFERRED BY ____

OCCUPATION____

ACTIVITIES & HOBBIES________________________________

1. **Have you had any previous eye surgery?** ☐ **Yes** ☐ **No**

2. **If yes, type:**____

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

3. **Do you wear eyeglasses, contact lenses or both?**
   - ☐ **Glasses** (skip to question 5)
   - ☐ **Contact Lenses** (skip to question 4)
   - ☐ **Both** (skip to question 4)

4. **Do you wear soft or rigid contact lenses?** ☐ **Soft** ☐ **Rigid**

5. **Has the prescription for your glasses and/or contacts been stable over time?** ☐ **Yes** ☐ **No**

General Medical History (please mark an X in the appropriate box)

6. 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			
Gastrointestinal Disease			
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			

	Yes	No	List Here
7. Do you use any eyedrops?			

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

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

9. Do you take any of the following medications?

	Yes	No	
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)

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

	Yes	No	please specify
Cataract			____________
Corneal dystrophies			____________
Keratoconus			____________
Collagen vascular disease/Arthritis			____________
Diabetes			____________
Glaucoma			____________
Macular degeneration			____________
Retinal detachment			____________
Other, specify			____________

11. What is your primary motivation for surgery? (please check all that apply)

Contact lens intolerance	☐
Recreational reasons	☐
Occupational requirements	☐
Cosmetic reasons	☐
Other problems with glasses and/or contacts (please specify)______________	☐

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

____

Patient signature **Date** ☐☐ month ☐☐ day ☐☐ year