CLEARSIGHT™
LASER CENTER

REFRACTIVE SURGERY PATIENT QUESTIONNAIRE

Name: _____ **DATE:** _____

This information is strictly confidential. The answers will help determine if you are a suitable candidate. Certain health problems may indicate potential problems with healing. Please elaborate on all "yes" answers.

MEDICAL HISTORY:

1. Are you allergic to any medications? ☐ Yes ☐ No
   If yes, please list: _____
2. Have you ever taken or are currently taking Imitrex, Accutane or Cordarone? ☐ Yes ☐ No
   If yes, please circle above: _____
3. Do you take any medications on a regular basis, including birth control? ☐ Yes ☐ No
   If yes, please list: _____
4. Are you planning on pregnancy within the next year? Are you nursing? ☐ Yes ☐ No
5. Do you have a pacemaker? ☐ Yes ☐ No
6. Do you have any history of:
   ☐ Asthma / Eczema ☐ Heart Problems ☐Diabetes
   ☐ Autoimmune Disease (Crohn's Disease, Lupus, Rheumatoid Arthritis, Etc.) ☐Hepatitis
   ☐ High Blood Pressure ☐ Hiv Postive / AIDS ☐Rosacea ☐ Other:_____

EYE HISTORY:

1. How old were you when you first started wearing glasses? _____

2.

Any eye disorders	☐ Yes	☐ No	Retinal tear or detachment	☐ Yes	☐ No
Glaucoma (High eye pressure)	☐ Yes	☐ No	Cataract	☐ Yes	☐ No
Dry eye syndrome	☐ Yes	☐ No	Recurrent corneal erosion	☐ Yes	☐ No
Amblyopia ("lazy eye")	☐ Yes	☐ No	Keratoconus	☐ Yes	☐ No
Any eye injury	☐ Yes	☐ No	Any eye dystrophy or degeneration	☐ Yes	☐ No
Eye surgery	☐ Yes	☐ No	Any herpes infection in the eye	☐ Yes	☐ No
ALK/RK/LASIK/PRK Surgery	☐ Yes	☐ No	Other	☐ Yes	☐ No
Any infection in the eye	☐ Yes	☐ No			

If **YES** to any of the above, please explain: _____

CONTACT LENS HISTORY:

1. In what year did you first started wearing contact lenses? _____ What type? _____

2. What kind do you wear now? _____ How many hours a day _____

3. When did you last wear your contacts? _____

REASONS FOR WANTING REFRACTIVE SURGERY: (Check all that are applicable)

☐ Job requirement ☐ Can't wear contact lenses ☐ Recreational activity (swimming, skiing, etc.)
☐ Cosmetic (I hate my glasses) ☐ Improved functional ability ☐ Simply Fed Up
☐ Reduce dependence on glasses/contacts ☐ Other

1. What concerns do you have about having laser vision correction? _____

2. When would you be interested in having laser vision correction if you are considered a candidate? _____