



3830 West Front Street
 Traverse City, MI 49684
 231-929-3888

CORNEAL REFRACTIVE SURGERY REGISTRATION

PATIENT INFORMATION

Name: _____ Birth Date: _____ Age: _____ Sex: M___ F___
(First) (MI) (Last) Month day year

Address: _____
Street City State Zip

Home: _____ Cell: _____ Work: _____

Email: _____

Occupation: _____ Employer: _____

Do you have a specialized Driver's License? ___CDL ___Pilot ___Motorcycle ___Other: _____

Do you have any special vision requirements or restrictions for your job?

Emergency contact name: _____ Phone: _____

INTEREST IN LASIK

Rate your satisfaction of your current glasses/contacts:
 ___Extremely Satisfied ___Very ___Somewhat ___Not Very ___Not at all

What activities or hobbies would you enjoy more without the dependency of glasses/contacts? (swimming, skiing, movies, etc.)

How did you hear about us?

How many LASIK providers are you evaluating? ___One ___Two ___More than two

What is your biggest concern about having LASIK?

Will you use funds from an employer sponsored flexible spending plan to pay for this procedure? ___Yes ___No

RELEASE OF INFORMATION/OTHER

I understand that this evaluation is for laser vision correction purposes only and is not a substitute for a routine eye examination. If I wish to have a copy of my examination records released to myself or another provider, I acknowledge that there may be a \$75 charge to me. I further understand that for internal training purposes only, my preoperative examination may be recorded with video and/or audio equipment. I understand that the LASIK evaluation is \$250 which applies towards my surgery if performed within 90 days.

 Signature of patient

 Date



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Name: _____

Birth Date: _____

MEDICAL HISTORY

Do you have or have you ever been treated for the following:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Currently Pregnant/Nursing |
| <input type="checkbox"/> Seizure | <input type="checkbox"/> Stomach Disorder | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Brain Tumors | <input type="checkbox"/> Digestive Disease | <input type="checkbox"/> Bypass Surgery | <input type="checkbox"/> Sarcoid |
| <input type="checkbox"/> Brain/nerve disorders | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Other Heart Disease | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Acne Rosacea |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Irregular Heart Rhythms | <input type="checkbox"/> Keloids |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> HerpesZoster (Shingles) |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Nephritis | <input type="checkbox"/> Other Lung Disorders | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Prostate Disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sleep Disorders |
| <input type="checkbox"/> MS | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Cancer or tumor, Type: _____ | |
| <input type="checkbox"/> Inflammatory Bowel Disease | | <input type="checkbox"/> Other _____ | |

Do you have an implanted pacemaker, defibrillator, or other battery powered medical device? Yes No

Please list any previous surgical procedures that you have had: _____

Do you currently take any of the following medications? (Please check all that apply)

- | | | | | |
|--|---|--|---|--|
| <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Beta Blockers | <input type="checkbox"/> Anti-Depressants | <input type="checkbox"/> Diuretics (Lasix) |
| <input type="checkbox"/> Hormone Replacement Therapy | <input type="checkbox"/> Accutane (even previously) | <input type="checkbox"/> Cordarone | <input type="checkbox"/> Imitrex | |

List all current medications and dosage: _____

I take no medications

List all medications that you are ALLERGIC to: _____

I have no known drug allergies

Primary Care Doctor's Name: _____

Phone Number: _____

EYE HEALTH HISTORY

When was your last eye exam? _____

Have you experienced any of these eye/health issues in the last 3-6 months?

- | | | | | |
|--|--|---|--|----------------------------------|
| <input type="checkbox"/> Stinging | <input type="checkbox"/> Tearing | <input type="checkbox"/> Itching | <input type="checkbox"/> Grittiness | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Dryness | <input type="checkbox"/> Glare | <input type="checkbox"/> Redness | <input type="checkbox"/> Trouble with night vision | |
| <input type="checkbox"/> Occasional Blurred Vision | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Eye Abrasion or Erosion | | |
| <input type="checkbox"/> Decreased contact lens wearing time | <input type="checkbox"/> Light Sensitivity | <input type="checkbox"/> Ocular Discomfort (aching) | | |

Have you or a family member (parent or sibling) ever been diagnosed with or treated for:

- | | | |
|---|--|---|
| Cataracts <input type="checkbox"/> Self <input type="checkbox"/> Family | Glaucoma <input type="checkbox"/> Self <input type="checkbox"/> Family | Strabismus (eye turn) <input type="checkbox"/> Self <input type="checkbox"/> Family |
| Retinal Disease <input type="checkbox"/> Self <input type="checkbox"/> Family | Amblyopia (lazy eye) <input type="checkbox"/> Self <input type="checkbox"/> Family | Diabetes <input type="checkbox"/> Self <input type="checkbox"/> Family |
| Blindness <input type="checkbox"/> Self <input type="checkbox"/> Family | Keratoconus or other corneal disease <input type="checkbox"/> Self <input type="checkbox"/> Family | |

Have you ever had any surgery, injury or laser treatments to the eye? No Yes (please describe below)

How are you currently managing your vision condition:

Glasses How old are your current glasses?: _____

Contacts: Type: Soft Toric Gas Perm

Do you sleep in them? Yes No How many years have you worn contacts? _____

When did you last wear your contacts? _____