Cedar Run
Eye Center

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:

___Stroke ___Ulcer ___Heart Disease ___Currently Pregnant/Nursing
___Seizure ___Stomach Disorder ___Heart Attack ___Rheumatoid Arthritis
___Brain Tumors ___Digestive Disease ___Bypass Surgery ___Sarcoid
___Brain/nerve disorders ___Hepatitis B or C ___Other Heart Disease ___Lupus
___Migraines ___Liver Disease ___High Blood Pressure ___Acne Rosacea
___Emphysema ___Kidney Stones ___Irregular Heart Rhythms ___Keloids
___Asthma ___Kidney Infection ___Thyroid Disease ___HerpesZoster (Shingles)
___Tuberculosis ___Nephritis ___Other Lung Disorders ___Psoriasis
___Prostate Disease ___Pneumonia ___Diabetes ___Sleep Disorders
___MS ___HIV/AIDS ___Cancer or tumor, Type:_____
___Inflammatory Bowel Disease ___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)

___Birth Control Pills ___Antihistamines ___Beta Blockers ___Anti-Depressants ___Diuretics (Lasix)

___Hormone Replacement Therapy ___Accutane (even previously) ___Cordarone ___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?

___Stinging ___Tearing ___Itching ___Grittiness ___Burning

___Dryness ___Glare ___Redness ___Trouble with night vision

___Occasional Blurred Vision ___Double Vision ___Eye Abrasion or Erosion

___Decreased contact lens wearing time ___Light Sensitivity ___Ocular Discomfort (aching)

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

Cataracts ___Self___Family Glaucoma ___Self ___Family Strabismus (eye turn) ___Self ___Family

Retinal Disease ___Self___Family Amblyopia (lazy eye) ___Self___Family Diabetes ___Self___Family

Blindness ___Self___Family Keratoconus or other corneal diease ___Self___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?_____