Lasik Consultation Questionnaire

1. Do you currently wear contact lens?
   Yes No
   If so, are they rigid or soft lens? Do you sleep in them?
   Rigid Soft Yes No

2. Have you ever been treated for dry eyes?
   Yes No

3. Are you currently being treated for Acne Rosacea?
   Yes No

4. Do you currently take anti-anxiety Medications, such as Prozac, Xanax or Valium?
   Yes No

5. Are you on hormone replacement therapy?
   Yes No

6. Do you suffer from chronic allergies?
   Yes No

   If so, what medications do you currently take?
   ____
   ____

7. Do you use any eye drops?
   Yes No
   If so please list current drops.
   ____
   ____

8. Are your eyes sensitive to light?
   Yes No

9. Do you experience problems with night vision? If so please describe.
   ____
   ____

10. On average, how many hours do you read or use a computer in a day?
    2-4 hours 4-6 hours 6-8 hours 8 or more hours

11. How did you hear about our practice? __________________________________
    ____
    ____