

GENERAL INFORMATION

Name: (First) _____ (Last) _____ Preferred Name: _____

Date of Birth: ____/____/____ Age: ____ Gender: ☐ M ☐ F ☐ _____

Address: _____ City: _____ State: ____ Zip: _____

Home: (____) _____ Work: (____) _____ Cell: (____) _____

E-mail: _____ Preferred contact: ☐ Home ☐ Work ☐ Cell ☐ Text ☐ E-mail

Emergency Contact: Name: _____ Phone: _____ Relationship: _____

Employer: _____ Occupation: _____

Who is Your Eye Doctor? _____ Did your doctor refer you to us? ☐ Yes ☐ No

When was your last eye exam? _____

How did you hear about us? ☐ Eye doctor ☐ Internet search ☐ Website ☐ Former patient _____

Hobbies, sports, interests: _____

How long have you been considering LASIK/PRK? _____

What is your motivation for having LASIK/PRK? _____

When do you plan to have LASIK/PRK? _____

Are you interested in affordable payment plans? ☐ Yes ☐ No Is this your first LASIK/PRK consultation? ☐ Yes ☐ No

VISION HISTORY

Do you wear glasses? ☐ Yes ☐ No Do you wear contacts? ☐ Yes ☐ No When did you wear them last? _____

Type of contacts (check all that apply): ☐ Spherical ☐ Toric ☐ Daily wear ☐ Extended wear ☐ Multifocal

☐ Monovision ☐ RGP – Years worn? _____

Ocular history (check all that apply): ☐ No past eye history ☐ Other: _____

☐ Amblyopia/lazy eye ☐ Cataracts ☐ Corneal abrasion ☐ Dry eyes ☐ Glaucoma ☐ Herpes simplex/zoster

☐ Recurrent corneal erosion ☐ Retinal detachment ☐ Strabismus/eye turn ☐ Trauma/foreign body/scar

Do you or anyone in your family have the following? Keratoconus or Fuch's corneal dystrophy: ☐ No ☐ Yes

If so, circle which one and indicate relationship _____

Ocular surgery (check all that apply): ☐ No past eye surgery ☐ Other: _____

☐ LASIK ☐ PRK ☐ RK ☐ Corneal transplant ☐ Cataract ☐ Glaucoma ☐ Retina ☐ Strabismus



Patient Information

Name: (First) _____ (Last) _____

MEDICAL INFORMATION

Medication allergies: ☐ None ☐ Yes (including dyes and latex) - _____

Medications used (including birth control, aspirin, over-the-counter medications, supplements, and home remedies):

☐ None ☐ Yes - _____

Are you pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Past and current medical history (please check all that apply): ☐ No past medical history

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Accutane use | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Keloid former | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Lupus | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Mobility/posture issues | <input type="checkbox"/> Neck/back pain | <input type="checkbox"/> Pacemaker/defibrillator | |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Sjogren's syndrome | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Other autoimmune /collagen vascular disease / or additional health information: | | | |

ADDITIONAL INFORMATION

Is there anything else that you would like us to know about you? _____

ACKNOWLEDGEMENT

Prior to your procedure, your eye doctor or Holzman Laser Vision will use eye drops to dilate your pupils. While not mandatory, you may prefer to have a driver if dilation drops are used. Your near vision will be blurry for about 4 hours afterward.

By signing below, you: 1. Acknowledge that you have been informed of our Privacy Practices, 2. Acknowledge that you have access to a copy of these documents in the center, and 3. Agree that all information given on this form is true to the best of your knowledge.

Signature of Patient or Patient Representative

Date