Patient Information

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? Keratoconous 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

☐ Accutane use	☐ Asthma	☐ Cancer	☐ Diabetes
☐ Eczema	☐ Emphysema	☐ Epilepsy/seizures	☐ Hearing Loss
☐ Heart disease	☐ High blood pressure	☐ High cholesterol	☐ HIV/AIDS
☐ Keloid former	☐ Kidney disease	☐ Lupus	☐ Migraines
☐ Mobility/posture issues	☐ Neck/back pain	☐ Pacemaker/defibrillator	
☐ Psoriasis	☐ Rheumatoid arthritis	☐ Sjogren's syndrome	☐ Thyroid disease

☐ 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