

NAME: _____ AGE: _____

*DAYTIME PHONE: _____

***PLEASE ATTACH COPY OF PRESCRIPTION**

Refractive Eye Surgery Questionnaire

FAMILY HISTORY:

HAS ANYONE IN YOUR FAMILY UNDERGONE CORNEAL TRANSPLANTATION? YES___ NO___

HAS ANYONE IN YOUR FAMILY BEEN GIVEN THE DIAGNOSIS OF KERATOCONUS? YES___ NO___

HAS ANYONE IN YOUR FAMILY NEEDED TO USE RIGID GAS PERMEABLE CONTACT LENSES? YES___ NO___

HAS ANYONE IN YOUR FAMILY UNDERGONE LASER CORRECTIVE EYE SURGERY WITH AN UNFAVORABLE OUTCOME OR SIDE EFFECTS? YES___ NO___

HAS ANY FAMILY MEMBER BEEN TOLD THAT THEY WERE A POOR CANDIDATE FOR LASER CORRECTIVE EYE SURGERY? YES___ NO___

PERSONAL HISTORY:

HAVE YOU EVER HAD AN EYE INFECTION FOR WHICH YOU SOUGHT MEDICAL CARE? YES___ NO___

HAVE YOU EVER DEVELOPED A BACTERIAL OR VIRAL INFECTION OF THE CORNEA? YES___ NO___

HAVE YOU EVER DEVELOPED A SCRATCH OR ABRASION TO THE CORNEA? YES___ NO___

HAVE YOU EVER HAD A COLD SORE OR FEVERBLISTER ON YOUR LIPS OR NOSE? YES___ NO___

HAVE YOU EVER UNDERGONE EYELID SURGERY? YES___ NO___

ARE YOUR EYES ESPECIALLY DRY OR IRRITATED IN THE MORNING? YES___ NO___

HAVE YOU BEEN TOLD THAT YOU SLEEP WITH YOUR EYES OPEN? YES___ NO___

DO YOU WAKE UP AT NIGHT OR IN THE MORNING WITH THE SENSATION THAT YOU HAVE A CONTACT LENS STUCK IN YOUR EYE? YES___ NO___

DO YOU HAVE A HISTORY OF BELL'S PALSY? YES___ NO___

DO YOU RUB YOUR EYES VIGOROUSLY FOR MORE THAN THREE MINUTES AT A TIME? YES___ NO___

WERE YOU EVER INTOLERANT OF SOFT CONTACT LENSES? IF SO, PLEASE DESCRIBE WHY. YES___ NO___