

LASER VISION CORRECTION QUESTIONNAIRE

PATIENT INFORMATION								
Name		Birthdate	Todays Date					
Address								
City	State	e	Zip Code					
Daytime/Work #		Home #						
Female	Male	SS #						
MEDICAL HISTORY								
✓ Do you have any current health conditions? (Arthritis, Diabetes, High Blood Pressure, Scarring Keloid, Pregnancy, Other)?								
✓ Do you take any medications?								
✓ Are you allergic to any medications?								
✓ Have you had any previous eye conditions/injury/surgery?								
FOR MARKETING PURPO	SES ONLY							
Occupation:		Email:						
Household income	: Less Than \$35,000	\$35,000 - \$75	5,000 \$75,000+					

	CT LENS / GLASSES WEAR						
√	Do you currently wear contact lenses? If yes, how many years have you worn/used contact lenses?						
	If you have worn them in the past, list reasons why you don't wear them anymore:						
√	Do you have an eye doctor,	; do you visit on a reg	ular basis?				
	If yes, please list th	If yes, please list their name(s): Ophthalmologist: Optometrist:					
	When was your las	·					
✓	What are your biggest prob	olems with contacts?					
✓	What are your biggest prob	olems with glasses?					
√	Please check any other reas	sons fir problems with	n glasses or contacts:				
	Comfort	Appeara	_	Vision			
	Nuisance	Depend		Peripheral Vision			
	Restricts Physical A	•		Safety			
	Occupation	•		,			
✓	What are your favorite leisure activities:						
/	One a scale of 1 – 5 with 1 being the least and 5 being the greatest, please indicate how						
	important are the following	g to you:					
·	Safety of Procedure	9					
	Experience of Doct	or					
	Cost/Expense						
	Long-term Studies						
	<u>-</u>	Financing Availability					
		Not Interfering with My Lifestyle					
	Talking to Former F						
✓	How long have you conside	red laser vision corre	ction before contactin	g the center?			
✓	Who or which of the following influenced you to contact the center?						
•	Relative	Friend	Doctor	Employee			
•							
•	Television	Radio	Newspaper	Magazine			