Lasik Screening

Name: _____ Date: _____

DOB/Age: _____ Occupation: _____

Why do you want to have lasik surgery?

_____

What activity do you want to do after surgery that is hindered by glasses/contacts?

_____

Do you wear contact lens? ☐Soft ☐Gas perm ☐Hard x _____yrs

_____

Have you ever had any trouble with dry eyes or inability to wear contacts?

_____

Have you ever had a severe eye infection, or herpetic eye infection?

_____

Have you ever had eye surgery in the past?

_____

Do you have any history of keloid scar formation?

_____

Do you have any history of Diabetes?

_____

Do you have any history of autoimmune disease, like Lupus, Thyroid or Arthritis?

_____

Do you take any of the following medicines? ☐No ☐Yes If so, check them.

☐Accutane ☐Imitrex ☐Norplant

Are you pregnant or nursing? ☐No ☐Yes

Do you plan on becoming pregnant? ☐No☐Yes When? _____

Do you have any history of multiple sclerosis or optic neuritis?

_____

Does your family have any of the above medical conditions?

_____

How did you hear about Dr. Leoni offering lasik surgery?

☐Friend ☐Newspaper ☐Radio ☐Mail ☐Website ☐Dr. _____

☐ Reviewed _____

Date Rick Leoni II, MD