LASER VISION CORRECTION
SCREENING QUESTIONAIRE

Patient Name: _____ Date: _____

1. What is your primary reason for considering Laser Vision correction?
   ( ) I would like to get LASIK for career reasons.
   ( ) I would like to get LASIK for lifestyle reasons (for example, sports, leisure activities, etc.)
   ( ) I think I look better without glasses and do not like contact lenses.
   ( ) I would like to reduce my dependence on glasses and/or contact lenses.

2. How long have you been considering having laser vision correction?
   ( )1 – 6 months
   ( )6 months – 1 year
   ( )1 – 2 years
   ( )2 years or longer

3. Do you know anyone who has had Laser vision correction surgery?
   ( )Yes
   ( )No

4. What type of refractive problem do you have? Check all that apply.
   ( )Astigmatism
   ( )Nearsighted
   ( )Farsighted
   ( )Presbyopia(readers)

5. Do you currently wear any type of visual correction?
   ( )Yes
   ( )No
   If yes, which?
   ( )Contact lenses ( )Distance
   ( )Glasses ( )Reading

6. If you wear contacts, are you having difficulties?
   ( )Yes
   ( )No

7. Are you experiencing any problems related to dry eyes?
   ( )Yes
   ( )No
   If yes, please specify _____

8. Do you think that after undergoing Laser vision correction you will have to wear contact lenses or glasses again?
   ( ) Yes
   ( ) No

9. Are you experiencing any glare/ light sensitivity?
   ( )Yes
   ( )No
   If yes, when?
   ( )Day
   ( )Night
   ( )Indoor
   ( )Outdoor
   ( )With bright lights

10. When do you feel your vision is best?
    ( )Day
    ( )Night
    ( )Both

11. Do you notice fluctuation in your vision?
    ( )Yes
    ( )No

12. Can you drive without glasses?
    ( )Yes
    ( )No

13. Are you experiencing problems with excessive tearing?
    ( )Yes
    ( )No

14. Are you experiencing double vision?
( )Yes
( )No

15. Do you ever have difficulty seeing at night?
( )Yes
( )No

16. Are you experiencing any color vision problems?
( )Yes
( )No

17. Has your refraction (vision with glasses and/or contacts) been stable over the past year?
( )Yes
( )No

18. Have you ever had any prior eye surgery?
( )Yes
( )No
If yes, specify:
( )Radial Keratotomy
( )Astigmatic Keratotomy
( )PRK
( )LTK
( )Cataract
( )Glaucoma
( )Retina
( )Other _____

19. Does anyone in your family have any eye disorders besides wearing glasses?
( )Yes
( )No
If yes, please specify _____

20. Do you participate in any contact sports?
( )Yes
( )No
If yes, please specify _____

21. How would you rate the quality of your vision without glasses/contact lenses?
( )Excellent
( )Good
( )Fair
( )Poor

22. How would you rate the quality of your vision with glasses/contact lenses?
( )Excellent
( )Good
( )Fair
( )Poor

23. Do you have any of the following conditions? (Select all that apply)
( )Keratoconus
( )Corneal Scarring
( )Glaucoma
( )Cataracts
( )Ocular Herpes diagnosed in past year
( )Retinal disease
( )Dry eye
( )None of the above

24. Do you have any of the following conditions? (Select all that apply)
( )Diabetes
( )Autoimmune disease (for example, AIDS, Lupus, rheumatoid arthritis, multiple sclerosis, or myasthenia gravis)
( )Immunocompromised for any reason
( )Collagen vascular disease
( )None of the above

25. Are you currently taking medications, such as steroids or immunosuppressants, Which can slow or prevent healing?
( )Yes
( )No
If yes, please specify_____
_____

26. Are you currently breastfeeding, pregnant, or planning to become pregnant within the next six months?
( )Yes
( )No