Keil Lasik Vision Center

PATIENT REGISTRATION

PATIENT INFORMATION

Name: **Birth Date:** **Age:** **Sex: M___ F___**

(First) (MI) (Last) Month day year

Address:

Street City State Zip

Home/Cell: **Work:** **Email:**

Occupation: **Employer:**

Do you have a specialized Driver's License? ___**CDL** ___**Pilot** ___**Motorcycle** ___**Other:**

Do you have any special vision requirements or restrictions for your job?

Emergency contact name: **Relationship:** **Phone:**

INTEREST IN VISION CORRECTION

Rate your satisfaction of your current glasses/contacts:

___Extremely Satisfied ___Very ___Somewhat ___Not Very ___Not at all

What activities or would you enjoy more without the dependency of glasses/contacts? (Reading, swimming, movies, etc.)

How did you hear about us?

How many surgeons are you evaluating for your procedure? ___One ___Two __More than two

What is your biggest concern about having vision correction surgery?

How long have you been considering having vision correction surgery? _____

How soon would you like to have your vision correction surgery? ___ASAP ___1-4 wks ___ 1-3 mos ___>3mos

Will you use funds from an employer sponsored flexible spending plan to pay for this procedure? ___Yes ___No

How much would you estimate your glasses/contacts have cost in your lifetime?

MEDICAL HISTORY

Do you have or have you ever been treated for the following:

___Stroke
___Seizure
___Brain Tumors
___Brain/nerve disorders
___Migraines
___Emphysema
___Asthma
___Tuberculosis
___Prostate Disease
___MS
___Inflammatory Bowel Disease
___Ulcer
___Stomach Disorder
___Digestive Disease
___Hepatitis B or C
___Liver Disease
___Kidney Stones
___Kidney Infection
___Nephritis
___Pneumonia
___HIV/AIDS
___Heart Disease
___Heart Attack
___Bypass Surgery
___Other Heart Disease
___High Blood Pressure
___Irregular Heart Rhythms
___Thyroid Disease
___Other Lung Disorders
___Diabetes
___Cancer or tumor, Type:_____
___Other_____
___ Pregnant/Nursing in past 3 mo.
___Rheumatoid Arthritis
___Sarcoid
___Lupus
___Acne Rosacea
___Keloids
___HerpesZoster (Shingles)
___Psoriasis
___Sleep Disorders
___ **None of the above**

Do you have an implanted pacemaker, defibrillator, or other battery powered medical device? ___Yes ___No

Please list any previous surgical procedures that you have had: _____

_____

Do you currently take any of the following medications? (Please check all that apply)

___Birth Control Pills ___Antihistamines ___Beta Blockers ___Anti-Depressants ___Diuretics (Lasix)

___Hormone Replacement Therapy ___Accutane (even previously) ___Cordarone ___Imitrex ___ **None of the above**

List all current medications and dosage:_____ OR

___I take no medications

List all medications that you are ALLERGIC to:_____ OR

___I have no known drug allergies

Primary Care Doctor's Name:_____ Phone Number:_____

EYE HEALTH HISTORY

When was your last eye exam? _____Where?_____

Have you experienced any of these eye/health issues in the last 3-6 months?

___Stinging ___Tearing ___Itching ___Grittiness ___Burning

___Dryness ___Glare ___Redness ___Trouble with night vision

___Occasional Blurred Vision ___Double Vision ___Eye Abrasion or Erosion

___Decreased contact lens wearing time ___Light Sensitivity ___Ocular Discomfort (aching) ___ **None of the above**

Have you or a family member (parent or sibling) ever been diagnosed with or treated for:

Cataracts ___Self___Family Glaucoma ___Self ___Family Strabismus (eye turn) ___Self ___Family

Retinal Disease ___Self___Family Amblyopia (lazy eye) ___Self___Family Diabetes ___Self___Family

Blindness ___Self___Family Keratoconus or other corneal diease ___Self___Family ___ **None of the above**

Have you ever had any surgery, injury or laser treatments to the eye? ___No ___Yes (please describe below)

How are you currently managing your vision needs:

I need correction for: ___Reading ___ Distance ___Both

___Glasses How old are your current glasses?: _____ How many years have you been wearing glasses?:_____

___Contacts: Type:___Soft ___Toric ___Gas Perm Do you sleep in your contacts? ___Yes ___No

How many years have you worn contacts?_____

When did you last wear your contacts?_____

RELEASE OF INFORMATION/OTHER

I understand that this evaluation is for laser vision correction purposes only and is not a substitute for a routine eye examination. If I wish to have a copy of my examination records released to myself or another provider, I acknowledge that there may be a charge to me. I further understand that for internal training purposes only, my preoperative examination may be recorded with video and/or audio equipment. If stated that I was referred by my Managed Care plan, I attest that I am a current member or eligible dependent of the Managed Care plan that I have checked above. Should it be determined that I am not an eligible member or dependent, I agree to reimburse the amount of the plan discount. Any applicable Managed Care discount must be indicated before payment or it will be forfeited. I authorize Dr. Keil and Keil Lasik to access any medical information from other providers pertinent to my care.

_____ _____

Signature of patient **Date**