SCREENING QUESTIONAIRE

Patient Name (Last, First, M.I)**: _____Rank: _____**

SS# (Last 4)**:_____**

List your hobbies or activities that require special visual needs (Example: skiing, woodworking, computers, sports, etc.):

_____

In your own words, please list what your expectations from eye surgery are:

_____

How long have you worn glasses? _____ Years, since age _____

Do you wear Contact Lenses? No If yes, for how long? _____ Years_____Months_____Hours per day
Last day worn _____

What Type of Contact Lenses? No Rigid gas perm No Soft

No Daily No Extended No Disposable No Occasional

Do you have, or have you ever had any of the following eye conditions:

No	Corneal Diseases	No	Keratoconus	No	Glaucoma
No	Herpes Keratitis	No	Elevated eye pressure	No	Amblyopia / Lazy eye
No	Eye Surgery / Laser	No	Cataract	No	Retinal Problems
No	Prism in eyeglasses				

Other eye problem or dates of eye surgery:

_____

Family History: No Keratoconus No Glaucoma

Other eye problems: _____

Do you have or have you been treated for the following medical problems?

No Connective tissue disease, autoimmune disease, immuno-deficiency (e.g. Rheumatoid Arthritis, Lupus, Sarcoid, HIV)?

No Diabetes? If so, for how long and what type? _____

No Smallpox vaccination in the last 3 months? If yes include the date._____

No Formed keloids? (E.g. heavy scarring over cuts, stitches or surgical incisions)?

No Taking any of these medications?
Accutane (isoretinoin) for acne, or Cordarone (amiodarone hydrochloride) for controlling irregular heartbeat, or Imitrex (sumatriptan) for migraine headaches? **How long:** **Last Used:**

No For female, have you been pregnant or nursing within the last 3 months?

Other health problems:

_____

List all medications you take regularly including over-the-counter medications and vitamins**:**

_____

_____

Are you allergic to any medications? (Please list and include any shellfish, iodine, and latex allergy):

_____

_____

Laser vision correction questions:

I understand that laser vision correction may not correct all of my myopia, hyperopia, and or astigmatism and that I may still need to wear glasses or contact lenses after laser surgery for the best correction of my vision.
_____ (patient initials)

I understand there is a chance I cannot be fit with contact lenses after laser vision correction.
_____ (patient initials)

I understand that reading glasses may be needed after laser vision correction, even if not needed now.
____ (patient initials)

Any recent hospitalizations or overnight stays at the hospital? No If yes, for how long? _____

Is your spouse (or someone who lives with you) a healthcare worker? No If yes, for how long? _____

Please SELECT the response that best describes your current symptoms. (Before Surgery)

Pre-op Symptoms	Right Eye	Left Eye
Dry Eyes	☐ 0 = none	☐ 0 = none
	☐ 1 = minimal	☐ 1 = minimal
	☐ 2 = mild	☐ 2 = mild
	☐ 3 = moderate	☐ 3 = moderate
	☐ 4 = severe	☐ 4 = severe
Glare / Haloes	☐ 0 = none	☐ 0 = none
	☐ 1 = minimal	☐ 1 = minimal
	☐ 2 = mild	☐ 2 = mild
	☐ 3 = moderate	☐ 3 = moderate
	☐ 4 = severe	☐ 4 = severe
Quality of daytime vision with current lenses	☐ 0 = excellent	☐ 0 = excellent
	☐ 1 = very good	☐ 1 = very good
	☐ 2 = good	☐ 2 = good
	☐ 3 = fair	☐ 3 = fair
	☐ 4 = poor	☐ 4 = poor
Quality of nighttime vision with current lenses	☐ 0 = excellent	☐ 0 = excellent
	☐ 1 = very good	☐ 1 = very good
	☐ 2 = good	☐ 2 = good
	☐ 3 = fair	☐ 3 = fair
	☐ 4 = poor	☐ 4 = poor
Overall satisfaction with your current lenses	☐ 0 = very satisfied	☐ 0 = very satisfied
	☐ 1 = somewhat satisfied	☐ 1 = somewhat satisfied
	☐ 2 = satisfied	☐ 2 = satisfied
	☐ 3 = mildly dissatisfied	☐ 3 = mildly dissatisfied
	☐ 4 = very dissatisfied	☐ 4 = very dissatisfied

Patient statement: "I certify that the above information is complete and correct to the best of my knowledge and that I have reviewed the Cadet Refractive Eye Surgery Program PDF"

Patient Signature: _____

Physician Signature_____

Revised: 05 January 2017 / Refractive Surgery