

Schneider LASIK

Patient Questionnaire

Patient Name:		Sex: (M/F)		DOB:		Age:	
Home Address:							

Street *City* *State* *Zip*

Home Phone:	()	Work Phone:	()	Cell #:	()
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Employer:	Work Address:
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Occupation:	SS #:
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E-Mail Address:	
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In case of emergency, who should be notified?	
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Relationship to patient:	Phone #:
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Primary type of corrective lens wear: (x)	Glasses		Contact Lenses		Both		None
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Type of glasses worn: (x)	Single Vision		Progressive Bifocal		Standard Bifocal		Trifocal
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How long:		Yrs		Mo	Dissatisfied with glasses because:
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Type of contact lenses worn:(x)	Soft		Hard		Gas Permeable		Torics		How long?		Yrs/Mo
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Please put an 'x' by any of the conditions below you have had, or are currently being treated for:

GENERAL HEALTH: (x)	Medications:
Diabetes	
Herpes/Cold Sores	
HIV+/Autoimmune Disorder	
Lupus	
Pacemaker	Women: If Pregnant, How long:
Rheumatoid Arthritis	Breast feeding? (yes/no)

Your hobbies:	
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On a scale of 1-10, how interested are you in having your vision corrected? <i>(1 = not interested; 10 = ready to improve vision)</i>	
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How soon would you like to have your vision corrected?	
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	Check or Cash
	Credit Card
	I would like to apply for financing

How did you hear about us? (x)	KFRG		Internet		TriCounty Eye		Yellow Pages
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Other:	
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Relative	Friend	Co-worker	Current or previous Lasik patient	If so who?	
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