Restore Vision Centers
The Specialists in Laser Vision Correction

Questions? 877-508-2020

PATIENT INFORMATION SHEET

(PLEASE COMPLETE THIS FORM AND BRING IT TO YOUR APPOINTMENT.)

Date: _______________

Last Name:____ Email :____

First Name:_____________________________________ MI:________ DOB:_____________ Age:_____ Gender: □ F □ M

Address:____ Occupation:____

City:________________________ State:______ Zip:______________ Employer:____

Telephone (H):______________________________ Message □ Y □ N Telephone (W):____________________ Message □ Y □ N

Telephone (C):______________________________ Message □ Y □ N Emer. Contact Name/ Ph.:________________________________

Please indicate what your current glasses contain: □ bifocals □ trifocals □ prism □ unknown

Please indicate any eye problems you have (other than the need for corrective lenses):

□ None □ Keratoconus □ Injury (scar) □ Retinal □ Corneal Disease □ Glaucoma □ Cataracts □ Amblyopia (lazy eye)

□ Previous surgery – please explain:____

Do you have any disease or medical conditions we should be aware of? □ Yes □ No

If yes, please explain:____

Have you ever had:

AIDS contact	□ Yes	□ No
HIV+ status	□ Yes	□ No
Blood Transfusion	□ Yes	□ No
Cold Sores / Herpes	□ Yes	□ No
Diabetes	□ Yes	□ No
Epilepsy	□ Yes	□ No
Hepatitis B	□ Yes	□ No
Hepatitis C	□ Yes	□ No
Keloid Scarring	□ Yes	□ No
Lupus	□ Yes	□ No
Myasthenia Gravis	□ Yes	□ No
Sexually Transmitted Disease	□ Yes	□ No
Tuberculosis	□ Yes	□ No

Please list all medications you are currently taking. Include dosage and frequency.

____

____

____

____

Please list any medication allergies.

____

____

____

____

Please read the following information and initial beside each line to indicate that you understand:

The night after your surgery should be free of strenuous activities. _________

You will not be able to drive home after your surgery; please arrange for transportation. _________

Your vision may be blurry for one week or more. Reading and driving may not be possible during this time. _________

Refractive surgery is not 100% predictable; further treatment may be required. _________

Most people require reading glasses beginning around age 40; refractive surgery will not prevent this. _________

Refractive surgery is not recommended if you are pregnant, plan to become pregnant in the next 3 months, or are nursing. _________

For what reasons are you considering refractive surgery?

□ Freedom from glasses and/or contact lenses □ Intolerance of contact lenses □ Occupational □ Sports □ Other: ________________

If you wear contact lenses, please answer the following:

Type of contact lenses:	□ Soft / Disposables	□ Toric	□ Rigid Gas Permeable	□ Hard (PMMA)
Frequency of use:	□ Daily	□ A few days a week	□ Sports / Social Events	□ Rarely

Date contacts last worn: ______________ Doctor initials:___________ Date: ______________________

Please arrange for someone to drive you home after your pre-operative diagnostic assessment since your eyes will have been dilated and your vision may be blurred, or you may have difficulty reading or driving. Restore Vision Centers is not responsible for any accident, injury or damage that might occur as a result of your blurry vision while dilated.

Patient Initials: __________________

8/2009

PLEASE FAX TO RESTORE VISION CENTERS AT 425-687-7703