

Patient Information

MR. MS. MRS. MISS (circle one)

First Name _____ Last Name _____ M _____

Address _____

City _____ State _____ Zip _____

Sex M F Age _____ DOB _____ SS# _____

Hm Ph.# _____ Bus Ph.# _____ Cell# _____

Employer _____ Occupation _____

E-Mail Address _____

Whom may we thank for referring you? _____

Who is your current eye doctor? _____ Phone# _____

Emergency Contact Information

Name _____ Relationship _____ Phone# _____

- How long have you been considering LASIK or another vision correction option?

- Have you been told in the past that you were a candidate for LASIK and if so, how long ago and by whom?

- What prompted you to schedule your consultation with our practice?

- What activities will you be able to more fully participate in after your vision is corrected?

- What is most important to you in making a decision to have your vision surgically corrected?

- What is your desired outcome from today's visit?

Assignment and Release

- Refractive procedures are elective and not generally covered by insurance. I understand that unless there is a contractual obligation or prior agreement if you should file my insurance or agree to any alternative form of payment including payment from any third party I am still ultimately responsible for and guarantee the payment of all fees owed.
- During a refractive consultation it may be necessary to dilate my eyes to confirm my candidacy. Dilating drops may blur vision for a length of time that varies from person to person. I authorize Dr. Updegraff and/or his associates to administer dilation drops during any of my consultation visits.
- Should I choose to schedule surgery, I understand that I am responsible for a scheduling deposit today to secure my surgical date.
- In the event that I must cancel my surgical date, I understand that my scheduling deposit is refundable up to 48 hours prior to the scheduled procedure.
- I acknowledge that I have received your Patient Information Privacy Notice.
- I understand this is an initial consultation only to determine my candidacy for a refractive procedure. Unless I follow up with surgery or regular office visits no doctor patient relationship has been established and no information from this consult will be released to anyone.

Patient Signature

Date



HEALTH HISTORY FORM

UPDATED _____

NAME: _____

DATE: _____

- YES NO HEART DISEASE
- YES NO HEART ATTACKS/ ANGINA WITHIN LAST 2 YEARS
- YES NO HIGH BLOOD PRESSURE
- YES NO ASTHMA/ COPD
- YES NO RECENT BRONCHITIS OR COLD
- YES NO DIABETES NIDDM/ INSULIN DEPENDENT
TYPE OF INSULIN _____
- YES NO KIDNEY DISEASE
- YES NO LIVER DISEASE/ HEPATITIS
- YES NO ULCER
- YES NO STROKES/ TIAs
- YES NO SEIZURES, CONVULSIONS OR FAINTING
- YES NO ARE YOU TAKING OR HAVE YOU TAKEN SABRIL?
- YES NO ARE YOU USING LATISSE?
- YES NO HEAD OR SPINAL INJURIES
- YES NO PERMANENT DEFECT FROM ILLNESS, DISEASE OR INJURY
- YES NO MUSCLE DISEASE
- YES NO TEMPORAL ARTERITIS
- YES NO ARTHRITIS/ LIMITED MOVEMENT
- YES NO CAROTID ARTERY-DISEASE
- YES NO PSYCHIATRIC DISORDER
- YES NO (WOMEN) ARE YOU PREGNANT
- YES NO HAVE YOU EVER BEEN ON
FLOMAX, CARDURA, HYTRIN, UROXATRAL?
- YES NO HIV
- YES NO DO YOU SMOKE _____ PKS PER DAY _____ WK _____ MO _____
- YES NO DO YOU DRINK _____ # PER DAY _____ WK _____ MO _____

HEIGHT _____ WEIGHT _____

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING AND THE DOSAGE:

ALLERGIES: _____

SURGICAL HISTORY (Please include Date and Type) PROBLEMS WITH ANESTHESIA YES _____ NO _____

OCULAR HISTORY (HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING IN THE PAST?)

- YES NO CATARACTS _____
- YES NO RETINA DISEASE _____
- YES NO CROSSED EYES _____
- YES NO IRITIS _____
- CATARACT SURGERY (date of surgery) RIGHT _____ LEFT _____
DO YOU HAVE IMPLANTS YES _____ NO _____
- RETINA SURGERY (Date of surgery) RIGHT _____ LEFT _____
- EYE INJURY : _____
- PREVIOUS SURGERIES: _____

FAMILY HISTORY (has anyone in your family (blood relative) has any of the following?)
(NOTE RELATION TO PATIENT: F- Father M- Mother P-Paternal M- Maternal S- Sister B- Brother
GF- Grandfather GM-Grandmother U- Uncle A- Aunt)

- YES NO GLAUCOMA _____
- YES NO CATARACTS _____
- YES NO CORNEA DISEASE _____
- YES NO MACULAR DEGENERATION _____
- YES NO RETINITIS PIGMENTOSA _____
- YES NO OTHER EYE PROBLEMS _____
- YES NO HEART PROBLEMS _____
- YES NO DIABETIC RETINOPATHY _____
- YES NO RETINAL DETACHMENT _____
- YES NO STROKE _____
- YES NO OTHER GENERAL HEALTH PROBLEMS _____

PRIMARY CARE PHYSICIAN:

PATIENT SIGNATURE: _____ **CONTACT PHONE NUMBER:** _____

TECH/ DR. NAME: _____ **DATE UPDATED/REVIEWED:** _____

CHANGES IN MEDICAL HISTORY OR MEDICATIONS SINCE LAST VISIT: YES _____ NO _____

CHANGES THAT HAVE OCCURRED: _____