

**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# \_\_\_\_\_

Has your current eye doctor ever suggested LASIK eye surgery to you? Y N

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 OR NURSING?
- 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: \_\_\_\_\_