



**SURGICAL EYE CARE, P.A. / BROWN LASER EYE CARE
REFRACTIVE SURGERY HISTORY SUPPLEMENT**

Name: _____ Date: _____

Employer: _____ Occupation: _____

Referred By: _____ E-mail: _____

Date of last eye exam: _____ Date of eyeglass prescription: _____

Do you wear glasses: Full time Part time Very little Never

Satisfaction with your glasses: *Best* 10 9 8 7 6 5 4 3 2 1 *Worst (circle one)*

Do you currently wear: Bifocals Reading glasses None

Do you wear contacts: Full time Part time No longer wear Never tried

Satisfaction with your contacts: *Best* 10 9 8 7 6 5 4 3 2 1 *Worst (circle one)*

What type of lenses do you wear: Soft Soft Torics Gas Perm (RGP) Hard

Specific Medical History:

Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Keloid Former	<input type="checkbox"/> Yes <input type="checkbox"/> No How Long: _____
Breast Feeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No Where: _____
Healing Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/ AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pace Maker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vascular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you take Imitrex?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Autoimmune Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use vitamins?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Why are you interested in elective refractive surgery? In other words, help us to understand your goals. Please check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> Convenience | <input type="checkbox"/> I now see poorly at distance without glasses and I would like this corrected. |
| <input type="checkbox"/> Contact Lens Intolerance | <input type="checkbox"/> I now see poorly at near without glasses and I would like this corrected. |
| <input type="checkbox"/> Appearance | <input type="checkbox"/> I am over 40 and my distance vision is fine without glasses. I want to be able to read without my glasses. |
| <input type="checkbox"/> Can't see well with glasses | <input type="checkbox"/> I am over 40 and my distance vision is poor without glasses. I want surgery to help me see good at distance and at near. |
| <input type="checkbox"/> Don't ever want to wear glasses again | |
| <input type="checkbox"/> Sports/ Leisure | |
| <input type="checkbox"/> Career requirement | |
| <input type="checkbox"/> for good vision, please explain _____ | |
| <input type="checkbox"/> Other hobbies and interests: _____ | |

Please check all that you are aware of:

- | | |
|---|--|
| <input type="checkbox"/> There are no guarantees in surgery. | <input type="checkbox"/> I may still need glasses following surgery. |
| <input type="checkbox"/> Laser Vision Correction does not fix the reading glasses problem (Presbyopia). | <input type="checkbox"/> Refractive Surgery is not for everyone. |

Signature: _____

Doctor only
Letter dictated to: _____ Date dictated: _____