

Boxer Wachler Vision Institute
Patient Medical and Eye Information
for
Refractive Evaluation

Name _____ Date _____
(Last) (First) (Middle)

Occupation _____ Employer _____

Date of Birth _____ Age _____ Gender _____

What frustrations do you currently have that relate to not being able to see as well as you like?

List three or four of the reasons why you are now considering a vision correction procedure?

Please share with us some of the physical activities that you hope to further participate in after your procedure?

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

What restrictions do you have now because of your use of contacts or glasses?

List medical symptoms that have been difficult to diagnose:

Glasses History

1. How often do you wear eyeglasses or contact lenses for distance vision? _____ Not at All _____ Part-time _____ Full-time

2. Do you need eyeglasses for reading? _____ Yes _____ No

Contact Lens History

3. Do you currently wear contact lenses? _____ Yes _____ No (if no, skip to 6)

4. What kind of contact lenses do you wear now? _____ soft _____ rigid gas permeable _____ hard

5. Are your contacts in today? _____ If not, how many days have they been out? _____

6. Have you tried monovision with contacts (one eye for distance vision, the other eye for reading)?

___ Yes ___ No

7. If you have tried monovision, was it successful for you? ___ Yes ___ No

Ocular History

8. List all eye surgeries you have had. Indicate _____
which eye and the date of surgery: _____

9. List all other surgeries you have had, with dates: _____

10. List eye injuries with dates: _____

11. List any eye diseases you have: _____

General Medical History

12. Do you now or did you in the past have any of the following conditions?

Please Specify

___ Yes	___ No	Atopic disease	_____
___ Yes	___ No	Rheumatoid arthritis	_____
___ Yes	___ No	Autoimmune Disease	_____
___ Yes	___ No	Diabetes	_____
___ Yes	___ No	Hepatitis	_____
___ Yes	___ No	HIV infection	_____
___ Yes	___ No	Keloid formation	_____
___ Yes	___ No	other medical problems	_____

13. List all eyedrops you use, which eye, and how often you use them: _____

14. List all other medications and supplements you take with dosage and frequency: _____

15. List any medications you are allergic to: _____

16. If female, are you; might you be; or trying to become; pregnant? Yes No

17. If female, are you breastfeeding? Yes No

Family Medical History

18. List any eye diseases that run in your family: _____

19. Have you visited our website? Yes No

20. What led you to make an appointment with us? _____

21. If you were referred to us, who referred you?

Doctor _____

Friend/Family _____ Is this person a patient of ours? Yes No

Address _____

Street City State Zip Code

Phone # (_____) _____

22. EYE DOCTOR _____

Name OPTOMETRIST/OPHTHALMOLOGIST

Phone _____ (circle one)

Address _____

23. MEDICAL DOCTOR _____

Name

Phone _____

Address _____

24. Any additional doctors or specialists providing you with medical care:

Name _____ Phone _____