Hollingshead Eye Center, P.C.

See the difference experience makes™

208-336-8700

FAX TO: 208-426-0902

Pre-Operative LASIK Evaluation

Name: _____ DOB: _____ Age: _____ Exam Date: _____

Address: _____ Sex: ☐ Male ☐ Female Surgery Date: _____

_____ Phone: (H) _____ Phone: (W) _____

SSN: _____ Optometrist: _____

Medical History: ☐ Healthy ☐ Lupus / RA ☐ Diabetes ☐ Hepatitis / AIDS ☐ Pregnant / Nursing ☐ Other

Ocular History: ☐ Healthy ☐ Cataract ☐ Glaucoma ☐ Corneal Disease ☐ Refractive Surgery ☐ Retina ☐ Other

Present Correction: ☐ Glasses ☐ DW Soft CTL (1) ☐ Soft Toric CTL (3) ☐ EW Soft CTL (3) ☐ PMMA / RGP CTL (4)

Last Worn: 1wk 2wks 3wks 4wks

Medications / Allergies: ☐ None ☐ NKDA List: _____

EYE EXAM

Va sc OD 20 /_____ **Va cc OD 20/** _____

OS 20 /_____ **OS 20/** _____

Scotopic Pupil: OD _____ OS _____

IOP: OD _____ OS _____

Dominant Eye ☐ OD ☐ OS

☐ **Cover test**-ortho ☐ Other_____ ☐**EOMS-WNL** ☐Abn_____

CONFT. FIELDS ☐OD-FTFC ☐OS-FTFC ☐Abn_____

Pupils ☐PERRL ☐ NO APD ☐+APD

Manifest Refraction:

OD: _____ 20/ _____

OS: _____ 20/ _____

Cycloplegic Refraction:

OD: _____ 20/ _____

OS: _____ 20/ _____

Anterior Segment:

OD WNL	OD Abn		OS WNL	OS Abn
☐	☐	_____ **L/L**	☐	☐ _____
☐	☐	_____ **C/S**	☐	☐ _____
☐	☐	_____ **K**	☐	☐ _____
☐	☐	_____ **A/C**	☐	☐ _____
☐	☐	_____ **Iris**	☐	☐ _____
☐	☐	_____ **Lens**	☐	☐ _____

Posterior Segment

OD WNL	OD Abn		OS WNL	OS Abn
	_____	**C/D**		_____
☐	☐ _____	**Mac**	☐	☐ _____
☐	☐ _____	**Vit**	☐	☐ _____
☐	☐ _____	**Peri R**	☐	☐ _____

Notes: _____

_____

Co-Managing Practice Information:

Optometrist: _____ Telephone: _____ Fax: _____

Examiner Signature: _____ Address: _____

360 E. Mallard, Suite 110 Boise, ID 83706 208-336-8700

GENERAL MEDICAL HISTORY / REVIEW OF SYMPTOMS

Patient _____ DOB _____ Date _____
Occupation: _____ Pharmacy and location _____
Name of your **PRIMARY CARE PHYSICIAN:** _____
Please list all present medications: (if you need more space, please use a separate sheet)

	Name	Dosage (mg)	How Often	Why
1.				
2.				
3.				
4.				
5.				

Are you allergic to any medications or substances and what are your reactions to each? _____

Please list all previous major surgeries or injuries (other than the eye) and their approximate dates:

Do you now have, or have you previously had any of the following medical conditions and/or symptoms?

Condition/Symptom	yes	no		yes	no		yes	no
Diabetes	☐	☐	Kidney disease	☐	☐	Graves' Disease	☐	☐
Hypertension	☐	☐	Heart Disease	☐	☐	Multiple Sclerosis	☐	☐
COPD/Asthma	☐	☐	Stroke	☐	☐	Rosacea	☐	☐
Headache/Migraine	☐	☐	Arthritis/Lupus/Other	☐	☐	Sjogrens Syndrome	☐	☐
Bleeding/Transfusions	☐	☐	Hepatitis/Jaundice	☐	☐	Depression/Anxiety	☐	☐
HIV/AIDS	☐	☐	Syphilis/Gonorrhea	☐	☐	Osteoporosis	☐	☐
Ulcers/Acid Reflux	☐	☐	Thyroid/Hormonal	☐	☐	Skin Cancer	☐	☐
Tumor/Cancer	☐	☐	Weight/Appetite Loss	☐	☐	High Cholesterol	☐	☐
Anemia	☐	☐	Gynecological/Urinary	☐	☐	MRSA	☐	☐

Other: _____
Do you smoke? No/Yes Packs per day _____ How many years? _____ Former smoker? No/Yes
Do you drink alcohol? No/Yes How much? _____ How often? _____

EYE HISTORY

Referring Physician/Optometrist _____
Please describe briefly and clearly the main reason for your visit? _____

Please list for each eye all previous eye injuries, surgeries, lasers, or other treatments, the reasons for these, and their approximate dates: _____

Please list all eye drops or eye medications you are now using, how often, and in which eye: _____

Has anyone in your biologic (blood) family had any of the following

	yes	no	relationship		yes	no	relationship
Blindness/low vision	☐	☐	_____	Cancer	☐	☐	_____
Macular Degeneration	☐	☐	_____	Uveitis	☐	☐	_____
Migraines	☐	☐	_____	Asthma	☐	☐	_____
Melanoma	☐	☐	_____	Arthritis	☐	☐	_____
Depression	☐	☐	_____	Cataract	☐	☐	_____
Glaucoma	☐	☐	_____	Thyroid	☐	☐	_____
Multiple Sclerosis	☐	☐	_____	Diabetes	☐	☐	_____
Hypertension	☐	☐	_____	Seizures	☐	☐	_____
Hearing Loss	☐	☐	_____	Other	☐	☐	_____

Please turn the page over and complete the back

We are required by law to obtain information regarding the race and ethnicity of our patient population. If you prefer not to report this information, you may choose the boxes that state you prefer not to report.

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Prefer not to report

Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian
- ☐ White
- ☐ Other
- ☐ Prefer not to report

Language:

- ☐ English
- ☐ Spanish
- ☐ French
- ☐ Chinese
- ☐ Indian
- ☐ Other: _____
- ☐ Prefer not to report

Print your name: _____ Date: _____

QUESTIONS ON PREPARING FOR LASIK SURGERY VIDEO

The following questions cover important information contained in the video presentation. Please circle the answer you feel most correct. If you need more time to answer a question than the video presentation provides, skip that question and return to it when the program is over. Once you have completed the questions, compare your answers to those found at the bottom of the page.

1. TRUE or FALSE: LASIK will permanently change the shape of your cornea.
2. TRUE or FALSE: There are no guarantees as to exactly how well you will see after the procedure.
3. TRUE or FALSE: You may experience side effects such as haze, glare, halos, light sensitivity, dryness of the eyes that may not go away completely.
4. TRUE or FALSE: All eyes are capable of seeing 20/20 or better.
5. TRUE or FALSE: After the surgery, follow-up visits are not important.
6. TRUE or FALSE: There is the possibility that another operation may be necessary after the initial procedure to obtain the best level of vision correction.
7. TRUE or FALSE: It is possible that you might still need to wear glasses or contacts, or that LASIK could cause loss of vision.
8. TRUE or FALSE: You may experience mild to moderate discomfort for several days after the procedure.
9. TRUE or FALSE: LASIK will eliminate your need for reading glasses when you are over 40 years of age, or presbyopic.
10. TRUE or FALSE: The program that I watched covered all risks, side effects, and complications that could possibly occur either now or in the future with LASIK.

Use this space to write any questions or concerns you wish to ask your doctor or a staff member:

_____

_____

_____

ANSWER:

1. TRUE: LASIK will permanently change the shape of your cornea.
2. TRUE: There are no guarantees as to exactly how well you will see after the procedure.
3. TRUE: You may experience side effects such as haze, glare, halos, light sensitivity, and dryness of the eyes that may not go away completely.
4. FALSE: Not all eyes are capable of seeing 20/20 or better.
5. FALSE: After the surgery, follow-up visits are very important.
6. TRUE: There is the possibility that another operation may be necessary after the initial procedure to obtain the best level of vision correction.
7. TRUE: It is possible that you might still need to wear glasses or contacts, or that LASIK could cause loss of vision.
8. TRUE: You may experience mild to moderate discomfort for several days after the procedure.
9. FALSE: LASIK will not eliminate your need for reading glasses when you are over 40 years of age, or presbyopic, unless you have the monovision or blended vision procedure.
10. FALSE: The program that I watched did not cover all risks, side effects, and complications that could possibly occur either now or in the future with LASIK.

Signature of patient: _____ Date: _____