LASTER™ EYE CENTER

OCULAR HISTORY QUESTIONNAIRE

Patient Name _____ Date _____

Family Dr. _____ Referring Dr. _____ Last Eye Exam _____

Are you interested in Refractive Surgery (LASIK, Intacs)? ☐ Yes ☐ No

Are you interested in Contact Lenses? ☐ Yes ☐ No If "***yes***"; ☐ previous wearer or ☐ never worn

List any **eye surgeries** you have had. (cataract, LASIK, RK, retinal)

Do you **currently** have any problems in the following areas? (If "***yes***"; please provide explanation.)

	Yes	No	Explanation of Problems
Glaucoma, cataract, retinal disease, etc..			
Double vision			
Decreased or blurred vision spells			
Eye pain			
Floaters in your vision			
Flashing lights			
Eye injury			
Serious eye infection			
Dryness			
Sandy or gritty feeling			
Redness			
Mucous discharge			
Itching			
Burning			
Glare, light sensitivity			
Drooping eyelid			
In or out turning of eye, lazy eye			

FAMILY HISTORY

	Yes	No	Relationship to Patient (Mother, Father, Sister, Brother, Daughter, Son)
Glaucoma			
Diabetes			
Macular Degeneration			

SOCIAL HISTORY

Current occupation?

Do you drink alcohol? ☐ **YES** ☐ **NO** If Yes: ○ occasional ○ 1/day ○ 2-3/day ○ 4+/day

Do you smoke? ☐ **YES** ☐ **NO** If Yes: ○ occasional ○ 10/day ○ 1pack/day ○ 1+pack/day