ORANGE COAST ***Laser Vision Center***
Questionnaire

How did you hear about us? [ ]

Patient Name: ______________________ Sex: **M / F** DOB: __________

Home address: ______________ City: __________ State: ____ Zip: ______

Work address: ______________ City: __________ State: ____ Zip: ______

Home Phone: __________ Cell Phone: __________ Work Phone: __________

email address: ______________________________

Occupation ______________________________

Emergency Contact: __________ Phone: ________ Relationship: __________

What do you usually use : **Glasses / Contact Lenses / Both** Contact Lens type: **Soft / Hard**

Medications you're taking: ______________________________

____

Medication or Drug Allergies? **No / Yes** (if yes, what are they): ______________________________

____

Hobbies/ Special Visual needs: ______________________________

Did a friend or colleague refer you to our office? Who?: ______________________________

How do you prefer we contact you if necessary: ______________________________

Have you ever had any of the following conditions

(mark with an "x")

[ ] previous eye surgery
[ ] previous laser eye surgery
[ ] keratoconus
[ ] glaucoma
[ ] arthritis
[ ] cold sores
[ ] convulsions
[ ] diabetes
[ ] headaches (severe)
[ ] heart problems ______________
[ ] hepatitis
[ ] HIV +
[ ] autoimmune disorders (e.g. Lupus)

yes	no	
[ ]	[ ]	adhesive tape
[ ]	[ ]	anesthesia / type: __________
[ ]	[ ]	iodine
[ ]	[ ]	antibiotics
[ ]	[ ]	______________

Women only:

yes	no	
[ ]	[ ]	pregnant?
[ ]	[ ]	nursing?

____
signature date