



Keil Lasik Vision Center

PATIENT REGISTRATION

PATIENT INFORMATION

Name: _____ Birth Date: _____ Age: _____ Sex: M ___ F ___

(First) (MI) (Last) Month day year

Address:

Street City State Zip

Home/Cell: _____ Work: _____ Email: _____

Occupation: _____ Employer: _____

Do you have a specialized Driver's License? ___CDL ___Pilot ___Motorcycle ___Other:

Do you have any special vision requirements or restrictions for your job?

Emergency contact name: _____ Relationship: _____ Phone: _____

INTEREST IN VISION CORRECTION

Rate your satisfaction of your current glasses/contacts:

___Extremely Satisfied ___Very ___Somewhat ___Not Very ___Not at all

What activities or hobbies would you enjoy more without the dependency of glasses/contacts? (Reading, swimming, skiing, movies, etc.)

How did you hear about us?

How many surgeons are you evaluating for your procedure? ___One ___Two ___More than two

What is your biggest concern about having vision correction surgery?

Will you use funds from an employer sponsored flexible spending plan to pay for this procedure? ___Yes ___No

How soon would you like to have your vision correction surgery? ___ASAP ___1-4 wks ___1-3 mos ___>3mos

MEDICAL HISTORY

Do you have or have you ever been treated for the following:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Currently Pregnant/Nursing |
| <input type="checkbox"/> Seizure | <input type="checkbox"/> Stomach Disorder | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Brain Tumors | <input type="checkbox"/> Digestive Disease | <input type="checkbox"/> Bypass Surgery | <input type="checkbox"/> Sarcoid |
| <input type="checkbox"/> Brain/nerve disorders | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Other Heart Disease | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Acne Rosacea |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Irregular Heart Rhythms | <input type="checkbox"/> Keloids |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> HerpesZoster (Shingles) |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Nephritis | <input type="checkbox"/> Other Lung Disorders | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Prostate Disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sleep Disorders |
| <input type="checkbox"/> MS | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Cancer or tumor, Type: _____ | |
| <input type="checkbox"/> Inflammatory Bowel Disease | | <input type="checkbox"/> Other _____ | |

Do you have an implanted pacemaker, defibrillator, or other battery powered medical device? Yes No

Please list any previous surgical procedures that you have had: _____

Do you currently take any of the following medications? (Please check all that apply)

Birth Control Pills Antihistamines Beta Blockers Anti-Depressants Diuretics (Lasix)

Hormone Replacement Therapy Accutane (even previously) Cordarone Imitrex

List all current medications and dosage: _____ OR

I take no medications

List all medications that you are ALLERGIC to: _____ OR

I have no known drug allergies

Primary Care Doctor's Name: _____

Phone Number: _____

EYE HEALTH HISTORY

When was your last eye exam? _____ Where? _____

Have you experienced any of these eye/health issues in the last 3-6 months?

Stinging Tearing Itching Grittiness Burning

Dryness Glare Redness Trouble with night vision

Occasional Blurred Vision Double Vision Eye Abrasion or Erosion

Decreased contact lens wearing time Light Sensitivity Ocular Discomfort (aching)

Have you or a family member (parent or sibling) ever been diagnosed with or treated for:

Cataracts Self Family Glaucoma Self Family Strabismus (eye turn) Self Family

Retinal Disease Self Family Amblyopia (lazy eye) Self Family Diabetes Self Family

Blindness Self Family Keratoconus or other corneal disease Self Family

Have you ever had any surgery, injury or laser treatments to the eye? No Yes (please describe below)

How are you currently managing your vision needs:

I need correction for: Reading Distance Both

Glasses How old are your current glasses?: _____ How many years have you been wearing glasses?: _____

Contacts: Type: Soft Toric Gas Perm Do you sleep in your contacts? Yes No

How many years have you worn contacts? _____

When did you last wear your contacts? _____

RELEASE OF INFORMATION/OTHER

I understand that this evaluation is for laser vision correction purposes only and is not a substitute for a routine eye examination. If I wish to have a copy of my examination records released to myself or another provider, I acknowledge that there may be a charge to me. I further understand that for internal training purposes only, my preoperative examination may be recorded with video and/or audio equipment.

If stated that I was referred by my Managed Care plan, I attest that I am a current member or eligible dependent of the Managed Care plan that I have checked above. Should it be determined that I am not an eligible member or dependent, I agree to reimburse the amount of the plan discount. Any applicable Managed Care discount must be indicated before payment or it will be forfeited. I authorize Dr. Keil and Keil Lasik to access any medical information from other providers pertinent to my care.

Signature of patient

Date