

BLACK HILLS REGIONAL EYE INSTITUTE PATIENT CONSULTATION FORM

CONTACT INFORMATION (please print):

Full Name _____

Home Phone(_____)_____ - _____

Business Phone(_____)_____ - _____

Cell Phone (_____)_____ - _____

Email _____

What is the best way to contact you? Home Phone Business Phone Cell Phone Email

BRIEF HISTORY AND QUESTIONNAIRE

1) What brought you into your appointment today? (please select only one)

- | | | | |
|---|---|--------------------------------------|---|
| <input type="checkbox"/> Eye Institute Employee | <input type="checkbox"/> DVD Request Card | <input type="checkbox"/> Radio Ad | <input type="checkbox"/> Website/Internet |
| <input type="checkbox"/> Other Patient | <input type="checkbox"/> Friends/Family | <input type="checkbox"/> Rush Hockey | <input type="checkbox"/> Yellow Pages Ad |
| <input type="checkbox"/> Eye Institute Doctor | <input type="checkbox"/> Optometrist | <input type="checkbox"/> Trade Show | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Civic Center Advertising | <input type="checkbox"/> Promotion | <input type="checkbox"/> TV Ad | |

2) My main visual problem (check all that apply):

- Fine Print Near Vision Intermediate/Computer Distance Vision Night Driving

3) My current prescription is for (check all that apply):

- Myopia or Nearsightedness Hyperopia or Farsightedness Astigmatism
 Presbyopia (I wear bifocals or glasses for reading) Unsure at this time

4) Do you currently wear (check all that apply):

- Glasses for Distance Vision Progressive Glasses/Bifocal or Reading Glasses Disposable Contact Lenses
 Disposable Toric Contact Lenses Extended Wear Contact Lenses Monovision Contact Lenses
 RGP/Hard Contacts Other _____

5) Do you have a history of any of the following (check all that apply):

- Keratoconus Diabetes High Blood Pressure Thyroid Condition Dry Eye Glaucoma
 Keloid Former Past Eye Conditions _____ Former Surgeries _____

6) When was your last eye exam? _____

7) Who is your Optometrist? _____

8) Do you know any friends or family members who have had the LASIK procedure? Yes No

9) If you lost or misplaced your glasses or contacts, would you be able to function throughout the day? Yes No

10) Do your glasses or contacts interfere with your recreational activities or hobbies? Yes No

11) If you could function throughout your day without dependence on contacts or glasses, would you consider the procedure a success? Yes No

12) Did you know that LASIK is a two-step procedure? Yes No

13) Are you interested in learning about our various financing programs? Yes No

14) Is there anything preventing you from proceeding with LASIK other than financial concerns? Yes No

15) What is it about your glasses or contact lenses that currently prevent you from enjoying everyday living?

16) What do you hope to achieve by having the LASIK procedure that glasses and contacts currently do not provide you with?
Ex: sports, hobbies, recreational activities_____

17) How long have you been considering the LASIK procedure?_____

18) How much do you want to know about laser vision correction?

Every Detail Major High Points General Overview Bare Essentials

19) Do you have any fears regarding vision correction? Yes No

If yes, please list_____

20) Is this your first LASIK evaluation? Yes No

If no, where else have you visited?_____

If no, were you told you were a candidate for LASIK? Yes No