LASIK HISTORY

First Name____________________ Middle Initial____ Last Name________________________ Date____/____/____
Birthdate____/____/____ Address____
City____________________________ State______ Zip_____________
Home Phone____________________ Cell Phone____________________ Work Phone____________________
Social Security Number_________________________ Marital Status____________
Email____ Occupation________________________________
Pharmacy and Location_______________________________ Phone Number____________________
How did you hear about our office: ____
Primary Care Doctor____
Medical Heath Insurance Carrier____

PATIENT RELEASE FORM

The doctors/staff at Foulkes Vision Institute may release my medical information or answer questions about my care, either verbally or in writing, to the following:

Name/Relation____
Optometrist or Name of Practice, Address, & Phone ____________________________________
____

* If the service was offered at no Additional charge, would you be interested in seeing your Optometrist for your follow up care after LASIK/PRK? YES_____ NO_____

Do you have any allergies to medications? **No/Yes** If yes, explain ____________________________
____

List all medications you take, dosages and reason: (including aspirin, over-the-counter, and home remedies)
____
____
____

List all major injuries, surgeries and hospitalizations you have had: ________________________
____

Have you ever received a pneumonia vaccination? **No/Yes**
Have you received a flu shot this year? **No/Yes**
Are you pregnant or nursing? **No/Yes**
Do you currently use tobacco products? **No/Yes** Circle which: Cigarettes/Cigars/Chewing Tobacco
How much/often?__________________________________ If you quit smoking, when?_______________
Do you drink alcohol? **No /Yes** If yes, how often?____________________________________
Do you use any other recreational drug? **No/Yes** If yes, type and how often? __________________
Date of last eye exam: _____/_____/_____
Do you wear glasses? **No/Yes** If yes, how old is your current pair? ________________________
Do you wear contact lenses? **No/Yes** If yes, how old is your current pair?____________________
Type of contact lenses: (Circle all that apply) **Hard/Soft/ RGP/Toric/ Extended Wear(Sleep In)/Daily Wear**
Brand:______________________________
Do you drive? **No/Yes** Do you have difficulty driving? **No/Yes**
If yes, explain: ____

Please note any family history for following **EYE** conditions and who: self, parents, siblings, or grandparents.

Blindness ______	Cataracts ______
Crossed Eyes ______	Glaucoma ______
Macular Degeneration ______	Retinal Disease ______
Light Sensitivity ______	Double Vision ______
Loss of Vision ______	Dryness/Tearing ______
Itching ______	Redness ______
Glare/Halo ______	Recurrent Eye Pain ______
Herpes Simplex/Zoster Infection ______	Flashing Lights/Floaters ______
Recurrent Eye Infection ______	Keratoconus ______

Please note any family history for following **MEDICAL** conditions and who: self, parents, or siblings.

Allergies/Hay Fever ______	Asthma ______
Anxiety ______	Arthritis (Type) ______
Auto Immune Disease ______	Keloids/Healing Issues ______
Rosacea ______	Headaches/Migraines ______
Seizures ______	Kidney Disease ______
Cancer (Type) ______	Diabetes (Type) ______
High Blood Pressure ______	Thyroid Disease ______
High Cholesterol ______	Heart Disease ______
HIV/AIDS/Hepatitis ______	Sleep Apnea ______

ABOUT YOUR EVALUATION: Your appointment is to determine your candidacy for LASIK/PRK procedures. The comprehensive evaluation will determine your prescription as well as your overall ocular health. This exam will not assist you with a prescription for glasses or contact lenses. If you choose to try any type of corrective lenses (contacts or glasses) prior to surgery there is a $60.00 fee. This fee is not billable to any Insurance.

SIGNATURE ON FILE

We will bill any applicable insurance for services rendered. Having insurance is not a substitute for payment. It is your responsibility to pay any deductible, coinsurance, or any other balances not paid by your insurance. I authorize the release of any medical information to the Health Care Financial Administration and its agents. I understand the information will be used to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked in writing.

Patient Signature: ______________________ Date: ______________

Witness: ______________________ Date: ______________