Explanation of health history, where necessary. _____

_____

_____

_____

Do you consider your health? Good _____ Fair _____ Poor _____ .

Are you presently taking any medications or drugs? Yes _____ No _____ . If yes, what drugs are you taking?

_____

_____

Are you allergic to any medications? Yes _____ No _____ . If yes, which? _____

_____

_____

Have you ever had any serious eye disease, eye injury, or eye surgery? Yes _____ No _____

If yes, please explain _____

_____

_____

When was your last eye examination? _____

What is your previous eye doctor's name? _____

When was your last visit to your physician? _____

What is your physician's name? _____

Do you wear contact lenses? Yes _____ No _____ . If yes, which type? hard _____ soft _____

Are you interested in information about LASIK? Yes _____ No _____

Additional Comments: _____

_____

_____

Authorization for treatment _____