SOCIAL/LIFESTYLE HISTORY

Current occupation ________________________________

Do you drive? ❑ YES ❑ NO
Do you have visual difficulty when driving? ❑ YES ❑ NO
Do you have problems with night vision? ❑ YES ❑ NO
Have you ever tried to wear contacts? ❑ YES ❑ NO

Do you drink alcohol? ❑ YES ❑ NO
If YES how often? ________________________________
Do you smoke? ❑ YES ❑ NO
If YES, how many packs a day? ________________________________
Do you read Books ❑ daily ❑ weekly ❑ monthly
Magazines ❑ daily ❑ weekly ❑ monthly
Newspaper daily ❑ weekly ❑ monthly
Do you use a computer ❑ daily, how many Hrs____ ❑ weekly ❑ monthly
How often do you watch television ❑ daily, how many Hrs____ ❑ weekly ❑ monthly
How often do you visit the movie theater ❑ weekly ❑ monthly
Hobbies: ❑ Hiking ❑ Arts & Crafts ❑ Knitting or Sewing ❑ Mechanics ❑ Reading ❑ Internet ❑ Gardening
❑ Other____________
How much time do you spend on your hobbies ❑ daily, how many Hrs____ ❑ weekly ❑ monthly
Does your current vision affect the ability to fully enjoy your hobbies ❑ YES ❑ NO
Do you participate in Sports ❑ Football ❑ Golf ❑ Basketball ❑ Baseball ❑ Skiing ❑ Swimming ❑ Running
❑ Working Out ❑ Cycling ❑ Other____________
How much time do you spend on your sports ❑ daily, how many Hrs____ ❑ weekly ❑ monthly
Does your current vision affect the ability to fully enjoy your sports ❑ YES ❑ NO
Are you interested in having Lasik surgery ❑ YES ❑ NO
If No, why? ________________________________
What would be the determining factor for you? ❑ Need more info ❑ Not sure if a candidate ❑ Fear ❑ No Time ❑ Cost

FAMILY HISTORY

DISEASE	YES	NO	Relationship to Patient
Blindness	❑	❑	________
Cataract	❑	❑	________
Glaucoma	❑	❑	________
Macular degeneration	❑	❑	________
Retinal degeneration	❑	❑	________
Arthritis	❑	❑	________
Cancer	❑	❑	________
Diabetes	❑	❑	________
Heart attacks	❑	❑	________
High blood pressure	❑	❑	________
Kidney disease	❑	❑	________
Lupus	❑	❑	________
Sjogrens Syndrome	❑	❑	________
Stroke	❑	❑	________
Thyroid disease	❑	❑	________
Tuberculosis	❑	❑	________
Other	❑	❑	________

History reviewed. ❑ **No changes** ❑ **Additions as noted above** Pts. Initials ______

Physician's signature: ________________________ Date: ________________