TriCounty Eye Institute
Patient Questionnaire

Patient Name:		Sex: (M/F)		DOB:		Age:	
Home Address:							
	Street			*City*	*State*	*Zip*	
Home Phone:	**( )**	Work Phone:	**( )**		Cell #:	**( )**	
Employer:		Work Address:					
Occupation:				SS #:			
E-Mail Address:							
In case of emergency, who should be notified?							
Relationship to patient:				Phone #:			

Primary type of corrective lens wear: *(x)*	Glasses		Contact Lenses		Both		None		
Type of glasses worn: *(x)*	Single Vision		Progressive Bifocal		Standard Bifocal		Trifocal		
How long:		Yrs		Mo	Dissatisfied with glasses because:				
Type of contact lenses worn: *(x)*	Soft		Hard		Gas Permeable		Torics		How long?		Yrs/Mo

Please put an 'x' by any of the conditions below you have had, or are currently being treated for:

GENERAL HEALTH: *(x)*		Medications:	
Diabetes			
Herpes/Cold Sores		Allergies:	
HIV+/Autoimmune Disorder			
Lupus			
Pacemaker		Women:	If Pregnant, How long:
Rheumatoid Arthritis			Breast feeding? *(yes/no)*

Your hobbies:									
On a scale of 1-10, how interested are you in having your vision corrected? *(1 = not interested; 10 = ready to improve vision)*									
How soon would you like to have your vision corrected?									
							Check or Cash		
							Credit Card		
							I would like to apply for financing		
How did you hear about us? *(x)*	KFRG		Internet		TriCounty Eye		Yellow Pages		
Other:									
Relative		Friend		Co-worker		Current or previous Lasik patient		If so who?	