OCC LASIK

P: 905.212.9482 | F: 905.212.1012
www.occlasik.ca | info@occlasik.ca

REFRACTIVE SURGERY QUESTIONNAIRE

Welcome to Ontario Surgical Inc. We recognize that your eyes are very important to you. We would like to know how you use your eyes on a daily basis. Along with your eye exam, this info will assist us in recommending the best options for your eyes and your personal Lifestyle vision.

PERSONAL

First Name____________________ **Last Name**____________________

Date of Birth____________________ **Age**________

Occupation____________________ ☐ Active ☐ Retired ☐ Student

Email____________________

VISION

Do you need corrective lenses to improve your distance vision? ☐ Yes ☐ No

Do you use reading glasses? ☐ Yes ☐ No

Do you wear contacts? ☐ Yes ☐ No

If so, please check the type of contacts you wear:

☐ Soft/disposable ☐ Hard/RGP ☐ Toric ☐ Scleral ☐ Cosmetic ☐ Bifocal

How long have you been wearing contacts?____________________

When was the last day contacts touched your eyes?____________________

Do you wear them overnight? ☐ Yes ☐ No

Has your prescription been stable over the last two years? ☐ Yes ☐ No

Please check any other reasons for problems with glasses or contacts:

☐ Poor comfort ☐ Dependence ☐ Occupational limitations
☐ Poor cosmetic appearance ☐ Restricts my physical activity ☐ Safety/Security
☐ Nuisance

Do you have an eye doctor you visit on a regular basis? ☐ Yes ☐ No

If yes, please list name and locations:____________________

When was your last eye exam? ____________________

Do you have copies of your last Prescriptions? ☐ Yes ☐ No

MEDICAL

Have you ever had any eye injuries or surgeries? ☐ Yes ☐ No

If yes, please explain:____

____

Do you have any significant medical history? Please check:

- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Bleeding Tendencies
- ☐ STD
- ☐ Autoimmune Diseases
- ☐ Heart Disease
- ☐ HIV
- ☐ Stroke
- ☐ Asthma
- ☐ Rheumatic Fever
- ☐ Depression/Anxiety
- ☐ Hypertension
- ☐ Collagen Vascular Disease
- ☐ Connective Tissue Disease (e.g. Lupus)
- ☐ Stomach Ulcers
- ☐ Kidney Disease
- ☐ Pneumonia
- ☐ Alcoholism
- ☐ Drug Abuse
- ☐ Allergies to dust of pollen
- ☐ Other:____

Please list all current medications including tranquilizers, anti-depressants, birth control, steroids or immunosuppressants:____

____

If you currently take any of the following medications or have taken any in the last 3 months of your surgery date, please check:

- ☐ Accutane
- ☐ Frova
- ☐ Methotrexate
- ☐ Amerge
- ☐ Humira
- ☐ Relpax
- ☐ Axert
- ☐ Imitrex
- ☐ Tamoxifen
- ☐ Embril
- ☐ Maxalt
- ☐ Zomig
- ☐ Cordaron
- ☐ Pacerone

Please place an "X" on the following scale to describe your personality as best you can:

Easy Going ... Perfectionist

Do you have any allergies to medications, eye drops, contact sensitivity or latex? ☐ Yes ☐ No

If yes, please list:____

Women: **Are you pregnant?** ☐ Yes ☐ No **Breast Feeding?** ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

If yes, how much:____

Thank you for filling out our questionnaire.