The Lasik Center Medical Group, Alexandra Chebil, M.D. Inc.

Patient Name: _____ Sex: M / F Birth date: _____/_____/_____

Home Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

E-Mail Address: _____

SS#: _____ Employer: _____ Occupation: _____

Best way to contact you: cell phone / home phone / work phone / email Best Time? _____

Emergency contact: _____Phone# _____Relationship:_____

Reason for your visit: LASIK consultation/Eye Exam/Contact lenses/Botox & Fillers/Other_____

Do you wear: **Glasses or Contacts?** Contact Lens type: Soft__ Gas Permeable ____Bifocal_____

How old is your prescription? _____ Is it Accurate? _____

When was your last eye exam? _____

List any medication you are currently taking: _____

List any drug allergies: _____

How did you hear about us? Internet / Radio / Magazine ad / Mailer/ Referral/Other_____

Whom may we thank for referring you? _____

Have you ever had the following conditions? Please circle

Eye Surgery/Cataracts/Keratoconus / Glaucoma /Arthritis / Cancer /Diabetes / High Blood Pressure

Family History: Cataracts/Keratoconus/Glaucoma/Macular Degeneration/Retinal Disease/Diabetes

Please elaborate: _____

Please list any other illnesses, diseases, conditions or surgeries you may have had: _____
_____

Female Patients: are you Pregnant? Y/N Nursing? Y/N

Patient's Signature:_____Today'sDate:_____

LASIK Questionnaire

Name: _____ Exam Date: _____

1. How long have you worn corrective lenses? For _____years.
2. I normally wear (check one) _____Glasses _____ Contacts _____No Correction
3. Why are you interested in laser vision correction?

_____

4. What difficulties, irritations, or problems are you currently having wearing glasses/contacts?

_____

5. What activities do you want to participate in without glasses/contacts?

_____

6. Have you had friends or family who've had their vision corrected? If yes, what relationship are they to you (e.g., friend, relative, etc?)

_____

7. What questions or concerns do you have about laser vision correction?

_____
_____
_____

8. On a scale of 1-10, how interested are you in having your vision corrected?

1----------5---------- 10

(1=not interested; 5= Interested, but need more info; 10= Ready to have clear vision today.)

10. Since laser vision correction is not normally covered by insurance, how would you like to arrange payment for the procedure?

_____Cash or Credit Card _____ I would like to apply for affordable financing.

11. When do you anticipate having your vision corrected? (Check one)

____ As soon as possible _____ 1-3 months _____ 3-6 months_____ 6+ months

12. **Preferred date and time for LASIK? _____**

Thank You!

Please return to the front desk, fax to (949) 251-8945 or email to: info@dralexandra.com

Eye Exam Worksheet: Alexandra Chebil, M.D.

Patient Name: _____ Birth date: _____

Date of Exam: _____ Surgery Date: _____

Reason for examination:

_____

Soft contacts: _____ Hard/Gas perm. Contacts: _____ When removed? _____

	OD	OS
Auto refraction	_____	_____
Wavescan	_____	_____
K-readings	_____	_____
Glasses RX	_____	_____
	Add_____	Add_____
Contact RX	_____	_____

How old is the glasses prescription? _____ How old is the contact lens prescription? _____

Distance Vision with glasses	20/_____	20/_____
Distance Vision without glasses	20/_____	20/_____
Reading Vision with glasses	20/_____	20/_____
Reading Vision without glasses	20/_____	20/_____
Pupil Size	_____	_____
Pachymetry	_____	_____
Dominant eye	_____	_____
Manifest refraction	_____	_____
Dilated refraction	_____	_____
IOP	_____	_____
Input for laser	_____	_____