HAYDEN VISION

LASIK CHECKLIST

NAME _____ DATE _____

YES	NO	WITHOUT GLASSES OR CONTACT LENSES…
○	○	Do you have trouble seeing at distance?
○	○	Do you have trouble seeing up close?
○	○	Do you have night vision problems?
		Describe: _____
○	○	Do you have dry eye problems?
		When: _____
○	○	Are you pregnant or nursing?
○	○	Do you have severe diabetes or severe allergies?
○	○	Do you have any active eye disease such as glaucoma or cataracts?
○	○	Do you have collagen vascular, autoimmune or immunodeficiency diseases (for example: Rheumatoid arthritis, Lupus, AIDS)?
○	○	Do you show signs of keratoconus (corneal disease)?
○	○	Would you be satisfied if your natural vision was greatly improved even if you still had to wear glasses some of the time?
○	○	Do your glasses or contacts interfere with your recreational activities?
		Which activities: _____
○	○	Do you feel that good vision without glasses is more important to you than perfect vision with glasses?
○	○	If you are over age 40, is it acceptable to you that you will need glasses for reading after LASIK?
○	○	Do you have vision problems with reading or computer work?
○	○	Do you have vision issues, limitation, or restrictions with your work or profession? Describe: _____