Updegraff VISION
See the difference.
Precision LASIK™ and Cataract Center
888-USA-2015

Patient Data Sheet

Patient Information

MR. MS. MRS. MISS (circle one)

First Name _____ Last Name _____ M_____

Address_____

City _____ State _____ Zip_____

Sex M F Age _____ DOB_____ SS#_____

Hm Ph.#_____ Bus Ph.#_____ Cell# _____

Employer _____ Occupation _____

E-Mail Address _____

Whom may we thank for referring you?_____

Who is your current eye doctor?_____Phone#_____

Has your current eye doctor ever suggested LASIK eye surgery to you? Y N

Emergency Contact Information

Name _____ Relationship _____ Phone#_____

- How long have you been considering LASIK or another vision correction option?

  _____

- Have you been told in the past that you were a candidate for LASIK and if so, how long ago and by whom?

  _____

- What prompted you to schedule your consultation with our practice?

  _____

  _____

- What activities will you be able to more fully participate in after your vision is corrected?

  _____

  _____

- What is most important to you in making a decision to have your vision surgically corrected?

  _____

  _____

- What is your desired outcome from today's visit?

  _____

  _____

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Assignment and Release

- Refractive procedures are elective and not generally covered by insurance. I understand that unless there is a contractual obligation or prior agreement if you should file my insurance or agree to any alternative form of payment including payment from any third party I am still ultimately responsible for and guarantee the payment of all fees owed.
- During a refractive consultation it may be necessary to dilate my eyes to confirm my candidacy. Dilating drops may blur vision for a length of time that varies from person to person. I authorize Dr. Updegraff and/or his associates to administer dilation drops during any of my consultation visits.
- Should I choose to schedule surgery, I understand that I am responsible for a scheduling deposit today to secure my surgical date.
- In the event that I must cancel my surgical date, I understand that my scheduling deposit is refundable up to 48 hours prior to the scheduled procedure.
- I acknowledge that I have received your Patient Information Privacy Notice.
- I understand this is an initial consultation only to determine my candidacy for a refractive procedure. Unless I follow up with surgery or regular office visits no doctor patient relationship has been established and no information from this consult will be released to anyone.

_____ _____

Patient Signature Date

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HEALTH HISTORY FORM

UPDATED _____

NAME: _____ **DATE:** _____

YES NO HEART DISEASE
YES NO HEART ATTACKS/ ANGINA WITHIN LAST 2 YEARS
YES NO HIGH BLOOD PRESSURE
YES NO ASTHMA/ COPD
YES NO RECENT BRONCHITIS OR COLD
YES NO DIABETES NIDDM/ INSULIN DEPENDENT
TYPE OF INSULIN _____
YES NO KIDNEY DISEASE
YES NO LIVER DISEASE/ HEPATITIS
YES NO ULCER
YES NO STROKES/ TIAs
YES NO SEIZURES, CONVULSIONS OR FAINTING
YES NO ARE YOU TAKING OR HAVE YOU TAKEN SABRIL?
YES NO ARE YOU USING LATISSE?

YES NO HEAD OR SPINAL INJURIES
YES NO PERMANENT DEFECT FROM ILLNESS, DISEASE OR INJURY
YES NO MUSCLE DISEASE
YES NO TEMPORAL ARTERITIS
YES NO ARTHRITIS/ LIMITED MOVEMENT
YES NO CAROTID ARTERY-DISEASE
YES NO PSYCHIATRIC DISORDER
YES NO (WOMEN) ARE YOU PREGNANT OR NURSING?
YES NO HAVE YOU EVER BEEN ON FLOMAX, CARDURA,HYTRIN,UROXATRAL?
YES NO HIV
YES NO DO YOU SMOKE_____PKS PER DAY_____ WK_____ MO _____
YES NO DO YOU DRINK _____# PER DAY_____WK _____ MO _____

HEIGHT____ WEIGHT ____

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING AND THE DOSAGE:

ALLERGIES: _____

SURGICAL HISTORY (Please include Date and Type) **PROBLEMS WITH ANESTHESIA YES _____ NO ____**

OCULAR HISTORY (HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING IN THE PAST?)

YES NO CATARACTS _____
YES NO RETINA DISEASE _____
YES NO CROSSED EYES _____
YES NO IRITIS _____
CATARACT SURGERY (date of surgery) RIGHT _____ LEFT _____
DO YOU HAVE IMPLANTS YES _____ NO _____
RETINA SURGERY (Date of surgery) RIGHT _____ LEFT _____

YES NO CORNEA DISEASE _____
YES NO GLAUCOMA _____
YES NO INJURY _____
YES NO OTHER EYE DISORDERS _____

EYE INJURY : _____ PREVIOUS SURGERIES:

FAMILY HISTORY (has anyone in your family (blood relative) has any of the following?)
(NOTE RELATION TO PATIENT: F- Father M- Mother P-Paternal M- Maternal S- Sister B- Brother
GF- Grandfather GM-Grandmother U- Uncle A- Aunt)

YES NO GLAUCOMA _____
YES NO CATARACTS _____
YES NO CORNEA DISEASE _____
YES NO MACULAR DEGENERATION _____
YES NO RETINITIS PIGMENTOSA _____
YES NO OTHER EYE PROBLEMS _____

YES NO HEART PROBLEMS _____
YES NO DIABETIC RETINOPATHY _____
YES NO RETINAL DETACHMENT _____
YES NO STROKE _____
YES NO OTHER GENERAL HEALTH PROBLEMS _____

PRIMARY CARE PHYSICIAN:

PATIENT SIGNATURE: _____ **CONTACT PHONE NUMBER:** _____

TECH/ DR. NAME: **DATE UPDATED/REVIEWED:** _____

CHANGES IN MEDICAL HISTORY OR MEDICATIONS SINCE LAST VISIT: YES _____ NO _____
CHANGES THAT HAVE OCCURRED: _____