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LASIK Screening Questionnaire

Do you have trouble seeing far away or up close? _____
 How long has your prescription been stable? _____
 Do you wear contact lenses? Y N If YES, date last worn: _____
 What problems are you experiencing with your glasses and/or contacts? _____
 How long have you been thinking about having LASIK? _____
 What is your occupation? _____
 What are your hobbies? _____
 If you are a good candidate, how soon would you like to have the procedure? _____
 What (if anything) in the past has stopped you from proceeding with LASIK? _____
 Is there a chance you could be pregnant or nursing? Y N Are you planning to be pregnant within the next 6 months? Y N

OCULAR HISTORY

Y N Keratoconus
 Y N Corneal Erosions or Ulcers
 Y N Herpes Simplex Virus Keratitis
 Y N Lazy Eye
 Y N Dry Eyes
 Y N Thyroid Eye Disease
 Y N Lid Disease
 Y N Glaucoma
 Y N Macular Degeneration
 Y N Cataract
 Y N Retinal Tear or Detachment
 Y N Surgery or Injury to the Eye
 Y N Radiation Therapy

SYSTEMIC HISTORY

Y N Auto Immune Disorder
 Y N Imitrex (sumatriptan) Use
 Y N Cordarone (Amiodarone) Use
 Y N Accutane (Isotretinoin)
 Y N Diabetes
 Y N Psoriasis
 Y N Eczema
 Y N Organ Transplant

Other: _____

What I am looking for in LASIK/PRK with Newsom Eye (Please rate these in order of most important 1 to 6)

Financing _____
Facility _____
Technology _____
Experience and Reputation of Surgeon _____
Cost _____
Results _____

All of the above information is true and accurate to the best of my knowledge. I understand that this is a preliminary screening and does not constitute a true eye exam. Further examination is required to ensure that I am a candidate for Refractive Surgery.

Patient Signature: _____ **Date:** _____