1201 11th Avenue South ◆ Suite 501 ◆ Birmingham, AL 35205
phone 205.969.8100 ◆ fax 205.930.9050

Today's Date _____ **Patient ID#_____**

Patient Information

Last Name: _____First Name: _____Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: _____ Marital Status: _____

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

E-mail: _____

Occupation: _____ Employer: _____

How did you hear about us? _____

Do you want to receive information via email from Michelson Laser Vision? _____

Activities

- ☐ Water Sports
- ☐ Racquetball
- ☐ Aerobics
- ☐ Camping
- ☐ Boating
- ☐ Other _____
- ☐ Bicycling
- ☐ Tennis
- ☐ Skiing/Snow Boarding
- ☐ Hunting/Shooting
- ☐ Scuba Diving
- ☐ Motorcycling
- ☐ Running/Jogging
- ☐ Soccer
- ☐ Golf
- ☐ Weight Lifting
- ☐ Sky Diving
- ☐ Football
- ☐ Baseball

Lifestyle Needs Assessment – Personal Goals for Refractive Surgery

(e.g. "I would love to be able to see the football game from the upper deck")

_____

_____

Ocular History

1. Do you wear eyeglasses, contact lenses, or both to correct your vision? _____
2. Have you ever worn contact lenses? _____
3. Do you wear soft or rigid contact lenses? _____
4. Do you usually sleep in your contact lenses? _____
5. How often do you replace your contact lenses with a new pair? _____
6. Do you require bifocals or reading glasses for near tasks? _____
7. Do you use any eye drops? _____
8. Have you had any previous eye surgery? _____

For Questions 9 and 10: On a scale of 1 to 10 (1=very unsatisfied, 10=very satisfied), please rate the following:

9. How satisfied are you with the quality of your vision **without** glasses or contact lenses? _____ (1-10)
10. How satisfied are you with the quality of your vision **with** glasses or contact lenses? _____ (1-10)

For Questions 11 and 12: On a scale of 1 to 10 (1=does not occur, 10=severe), please rate the following:

11. If you wear glasses, rate the severity of the following conditions while wearing your glasses:

_____Glare _____Problems with vision during night driving

_____Difficulty reading _____Halo or rings around lights

12. If you wear contact lenses, rate the severity of the following conditions while wearing them:

_____Glare _____Problems with vision during night driving

_____Difficulty reading _____Halo or rings around lights

13. How **FREQUENTLY** do you experience the following dry eye symptoms (check one)?

Symptom	Never	Sometimes	Often	Constant
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

General Medical History

Please check the box if you currently have or have had any of the following conditions:

- ☐ Allergies/Asthma
- ☐ Arthritis
- ☐ Autoimmune Disease (Lupus, Rheumatoid Arthritis, etc.)
- ☐ Diabetes
- ☐ Herpetic Eye Infections
- ☐ Heart Disease
- ☐ Hypertension
- ☐ History of Keloid Formation
- ☐ Seizure Disorder
- ☐ Shingles
- ☐ Other, specify _____
- ☐ Stroke
- ☐ Thyroid Disorder

If Female:

☐ Currently Pregnant ☐ Currently Nursing ☐ On Hormone Replacement Therapy

Please list allergies to medications:

_____

Please list current medications (prescribed and over the counter):

_____

_____

Family Medical History

Has any close family member had any of the following:

- ☐ Cataract
- ☐ Corneal Dystrophies
- ☐ Collagen Vascular Disease
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Other, specify _____

To the best of my knowledge, the preceding information is complete and correct.

_____ _____

Patient Signature Date

MICHELSON LASER VISION, INC.

PROFESSIONAL FEE ACKNOWLEDGEMENT & RECEIPT

Initial consultation of new patients **No charge**

Evaluation & Examination for Laser Vision Correction **$150.00**

I (the patient) am completely aware of the fee in the amount of **$150.00** for the evaluation and examination for laser vision correction provided by the physicians and staff at Michelson Laser Vision, Inc. This fee must be paid in full and will be collected at checkout. This fee will be applied **to the total amount due for laser refractive surgery** at Michelson Laser Vision, Inc. and also provides for the privilege of having your records released. This fee is not refundable if the physicians determine you are not a candidate for laser vision correction or you decide not to have laser vision correction. This fee is not for the initial consultation of new patients, but for the examination performed by the physicians and staff of Michelson Laser Vision, Inc. to determine if you are a candidate for laser vision correction.

- -

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was offered a copy of Michelson Laser Vision, Inc.
Notice of Privacy Practices

Patient Name: _____ Date: _____

Signature of Patient: _____

Add any additional names below to receive medical information along with their relationship to the patient.

Name	Relationship
_____	_____
_____	_____
_____	_____