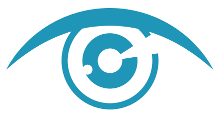

Jeffrey D. Horn, MD

VISION FOR LIFE

NAME: ______________________________

LASIK Checklist

YES	NO	
☐	☐	Do you have trouble seeing at a distance?
☐	☐	Do you have trouble seeing up close?
☐	☐	Do you have night vision problems?
		If yes, please describe: ______________________________
☐	☐	Do you have dry eye problems?
		If yes, please describe: ______________________________
☐	☐	Are you pregnant or nursing?
☐	☐	Do you have severe diabetes or severe allergies?
☐	☐	Do you have any active eye disorders (ex: glaucoma, cataracts)?
☐	☐	Do you have collagen, vascular, autoimmune or immunodeficiency diseases (ex: Rheumatoid arthritis, Lupus, AIDS)?
☐	☐	Do you show signs of keratoconus (corneal disease)?
☐	☐	Do you have vision problems with reading or computer work?
☐	☐	Do your glasses or contacts interfere with your recreational activities?
		If yes, which activities: ______________________________
☐	☐	Do you have vision issues, limitations or restrictions with your work or profession?
		If yes, please describe: ______________________________
☐	☐	Would you be satisfied if your natural vision was greatly improved even if you still had to wear corrective lenses some of the time?
☐	☐	Is it acceptable to you that you may need glasses for reading after LASIK?
☐	☐	Do you feel that good vision without glasses is more important than perfect vision with glasses?

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