Advanced Vision Correction Pre-Evaluation Questionnaire

Patient Name: ____

Your Occupation: ____**Your Age:**________

Please tell us a little about yourself…

1. How long have you worn eyeglasses and/or contact lenses? _______ years.

2. I normally wear (check one): ☐ Eyeglasses ☐ Contact lenses

3. Have you worn contact lenses then quit wearing them? ☐ Yes ☐ No
If Yes, what factors caused you to quit wearing contact lenses? _______________________

____

4. Why are you interested in advanced vision correction? ______________________________

____

5. What kinds of close work would you like to do without eyeglasses or contact lenses?

____

6. What activities do you want to participate in without eyeglasses or contact lenses? ________

____

7. Do you frequently use a computer monitor or video terminal? ☐ Yes ☐ No

8.. Have you had friends, family or co-workers who have had vision correction? ☐ Yes ☐ No
If Yes, what relationship are they to you? ____

9. What questions or concerns do you have about Advanced Vision Correction?

____

10. On a scale of 1 – 10, how interested are you in having your vision corrected?
(1=not interested, 5=interested, but need more information, 10=ready to have clear vision today)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

11. Since Advanced Vision Correction is not normally covered by insurance, how do you plan to pay for the procedure? ☐ Cash or check ☐ Credit card ☐ Financing

12. How soon do you want to have your vision corrected?
☐ As soon as possible ☐ In 1 to 3 months ☐ In 3 to 6 months ☐ In 6 months plus

Patient signature: ________________________________ **Date:**__________ ___________