CENTRAL ARKANSAS LASIK

Patient Registration

Name: (Last) ___________________(First)____________________ (M.I) __________

Date of Birth: ______________________ Age: _____________ Gender: ______________

Address: ____

City: ________________________ State: ________________ Zip Code__________________

Home/ Cell Phone: _____________________________Work Phone: _________________________

Email: ____

Employer: __________________________________ Occupation: ______________________________

Hobbies/ Sports ____

Last Eye Doctor? ______________________________________ Date of last eye exam: ___________

How long have you been considering vision correction surgery?____

Why do you want to have LASIK? ____

When do you want to schedule LASIK? ____

Did your Eye Doctor recommend Central Arkansas LASIK? ______________________

Medical Information:

Medical Allergies: ☐ None List: ____

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Environmental Allergies ☐ None List:____

Current Medications: ☐ None List: ____

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Medical History (please check) ☐ NONE

☐ Asthma / COPD ☐ Rheumatoid Arthritis ☐ Lupus ☐ Psoriasis
☐ High Blood Pressure ☐ Diabetes ☐ Stroke / CVA ☐ HIV
☐ Thyroid Disease ☐ Connective Tissue Disorder ☐ Depression ☐ Cancer_______________
☐ Keloid Scarring ☐ Pregnant / Breastfeeding ☐ Heart Disease

☐ Other Diseases____

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Eye History:

Past Ocular History: □ NONE

□ Dry Eyes □ Keratoconus □ Family history Keratoconus
□ Double Vision □ Lazy Eye/ Amblyopia □ Strabismus □ Recurrent Corneal Erosion
□ Cataracts □ Diabetic Retinopathy □ Eye Tumor □ Herpes Simplex or Zoster
□ Glaucoma □ Corneal Foreign Body □ Trauma □ Retinal Tear or Detachment

Past Ocular Surgery: □ NONE (ex. muscle surgery, retinal surgery, PRK, cataract surgery)

Please list:____
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Contact Lens History: □ NONE

□ Soft Daily Wear □ Rigid Gas Permeable
□ Soft Extended Wear □ Scleral Lenses
□ Soft Toric Lenes □ Soft Multifocal Do you sleep in your contact lenses? Yes / No (please circle)
□ History of a contact lens related ulcer

Date contacts last worn:______________________

Trouble with wearing contacts?:____

Emergency Contact Information:

Emergency Contact: ____Relationship: ________________
Phone number: ______________________ Cell Number: ________________________________
Prior to your procedure, your Eye Doctor will dilate your eyes with a pupil dilator drop. It is recommended that you have a driver if dilation drops are used.

By signing below, you agree that all information given on this form is true best of your knowledge.

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Signature of Patient or Personal Representative