Avant LASIK Spa Registration Form

Name:	**Date of Birth:**	**Age:**	**Gender:** M / F
Address:			
City:	**State:**	**Zip Code:**	
Home Phone:	**Cell Phone:**	**Work Phone:**	
E-Mail Address:			
Preferred Language:	**Race:** ☐ White ☐ Asian ☐ Black ☐ Other		
Employer:		**Occupation:**	
Address:			
City:	**State:**	**Zip Code:**	

Primary Care Physician:	**Office Phone:**	
Referring Physician:	**Office Phone:**	
Pharmacy:	**Location:**	**Phone:**
Current Medications:		
Allergies to Medications:		
Height:	**Weight:**	

Emergency Contact Name:	**Relation:**
Home Phone:	**Cell Phone:**

How many hours a day do you spend on the computer?:
How many hours a day do you spend reading?:
Hobbies:

Do you wear contact lenses?:	**If yes, how long have you worn contact lenses?:**
	How many hours per day:
Type of Contacts: ☐ Soft Lens ☐ Hard Lens ☐ Gas Perm Lens	

I attest that this information is accurate to the best of my knowledge.

Signature: ____ **Signature Date:**_____________________

AVANT LASIK SPA MEDICAL HISTORY QUESTIONNAIRE

Name: ________________________________ Date of Birth: ____/____/____ Last Eye Exam: ____/____/____

Primary Care Physician: ______________________ Referring/Specialty Dr.: _____________________________

Do you wear glasses? □ Yes □ No **Do you wear contact lenses?** □ Yes □ No

Are you currently experiencing any of the following? (Please mark all that apply)

□ Abnormal Head Position	□ Dry Eyes	□ Flashes of light/Floaters	□ Itchy Eyes/Lids
□ Blurry/Decreased Vision	□ Eye Injury	□ Glare/Light Sensitivity	□ Red Eye(s)
□ Double Vision `	□ Eye Pain	□ Growth/Bump in Lid	□ Watery Eyes
□ Droopy lid	□ Eye Misalignment	□ Headaches	□ Other _______________

Past Ocular History: (Please mark all that apply)

□ None	□ Cataract(s)	□ Hyperopia (Farsightedness)	□ Myopia
□ Amblyopia (Lazy eye)	□ Diabetic Retinopathy	□ Iritis	□ Optic Neuritis
□ Aphakia	□ Dry Eyes	□ Keratoconus	□ Retinal Detachment
□ Astigmatism	□ Glaucoma	□ Macular Degeneration	□ Other _______________

Ocular Surgeries: (Please mark all that apply)

□ None	□ Foreign Body Removal	□ Ptosis Repair	□ Trabeculectomy
□ Blepharoplasty	□ Retinal Laser	□ Punctal Plugs	(Glaucoma Surgery)
□ Cataract Surgery	□ RD Repair	□ Strabismus Surgery	□ Vitrectomy
□ Corneal Transplant	□ LASIK/PRK/RK	(Eye Muscle Surgery)	□ Other _______________

Ocular Significant Illnesses: (Please mark all that apply)

□ None	□ Diabetes	□ Hypertension	□ Parkinson's Disease
□ Bell's Palsy	□ Headache/Migraines	□ Hyperthyroidism	□ Rheumatoid Arthritis
□ Bleeding Disorder	□ Hepatitis C	□ Lupus	□ Sjogren's Syndrome
□ Brain Tumor	□ Herpes Simplex	□ Meningitis	□ Stroke /TIA
□ Cancer	□ Histoplasmosis	□ Myasthenia Gravis	□ Syphilis
□ Chicken Pox, Shingles	□ HIV+/AIDS	□ Multiple Sclerosis	□ Other _______________

Other Past Medical Illnesses: (Please mark all that apply)

□ None	□ Eczema	□ Kidney Disease	□ Psychiatric Disorder
□ Anemia	□Hearing Loss	□ Lung Disease	□ Seizures
□ Asthma	□ Heart Attack	□ Lupus	□ Skin Cancer
□ CHF	□ Hepatitis A/B	□ MRSA	□ Other _______________
□ COPD/Emphysema	□ Hypothyroidism	□ Osteoarthritis	□ Other _______________
□ Depression	□ Irregular Heart Beat	□ Polymyalgia	□ Other _______________

General Surgery/Operations:

Date:	Operation:
________________________	____
________________________	____
________________________	____
________________________	____
________________________	____

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Family History: (Please mark all that apply)

□ Blindness	□ Eye Misalignment	□ Hyperthyroidism	□Retinal Detachment
□ Cancer	□ Glaucoma	□ Lazy Eye (Amblyopia)	□ Stroke
□ Cataracts	□ Heart Disease	□ Macular Degeneration	□ Other ________________
□ Diabetes	□ High Blood Pressure	□ Migraines	

Medication Allergies:	**Type of Reaction:**
____________________________	____
____________________________	____
____________________________	____
____________________________	____
____________________________	____

Ocular Medications:	**Drug Name/Dose/Strength/Frequency**
____________________________	____
____________________________	____
____________________________	____
____________________________	____
____________________________	____

Systemic Medications:	**Drug Name/Dose/Strength/Frequency**
____________________________	____
____________________________	____
____________________________	____
____________________________	____
____________________________	____

Social History: (Please mark all that apply)

□ Alcohol ____ glasses/bottles per day/week	□ Smoking ____ packs/day	□ Occupation_________________
□ Pregnant	□ Nursing	