Print Form

MALONEY VISION INSTITUTE®

Vision Correction Surgery Patient History Questionnaire

Name:_____ Date: _____
(Last) (First) (MI)

Date of Birth: _____ Occupation: _____ Employer: _____

If an eye doctor suggested you see us, please provide the doctor's name: _____

List activities and hobbies that you enjoy: _____

_____

How does your vision impact your quality of life now?

_____

_____

_____

What are your biggest problems with contacts?

_____

_____

_____

What are your biggest problems with glasses?

_____

_____

_____

Please check any other reason(s) for problems with glasses or contacts:

- ☐ Poor comfort
- ☐ Poor cosmetic experience
- ☐ Tired of having poor vision
- ☐ Limits enjoyment of certain activities
- ☐ Nuisance
- ☐ Dependence
- ☐ Restricts my physical activity
- ☐ Other _____
- ☐ Poor peripheral vision
- ☐ Safety / Security
- ☐ Occupational limitations

Is this your first opinion about vision correction? ☐ Yes ☐ No

If not, where else have you visited? _____

What questions do you have that we could address during your consultation?

_____

_____

_____

Medical and Eye History

Does any family member have keratoconus? ☐ Yes ☐ No

Has any family member had a cornea transplant? ☐ Yes ☐ No

List all eye surgeries, injuries or diseases you have had:

_____

_____

List all elective or cosmetic surgeries you have had:

_____

_____

List all medical problems you have:

_____

_____

With glasses or contacts, how much nighttime glare or halos do you currently have?

☐ None ☐ Minimal ☐ Mild ☐ Moderate ☐ Severe

List all eye drops you use, which eye, and how often you use them:

_____

_____

_____

List any oral or injected medications you are taking:

_____

_____

_____

List any medications you are allergic to:

_____

_____

_____

If female, are you or might you be pregnant? ☐ Yes ☐ No