Hodges Eye Care and Surgical Center
The view from here is always clear.

Refractive Evaluation Patient Information

Patient Information Date_____/_____/_____

Name_____ Date of Birth_____/_____/_____ Age_____ Sex M/F

Address _____ Email address _____

City, State, Zip Code _____ Marital Status _____

Cell Phone # _____ Alternate Phone # _____

Employer _____ Occupation _____

Primary Care Physician _____ Optometrist _____

Emergency Contact Information Name _____ Relationship _____

Address_____

Home Phone # _____ Work # _____

Hobbies/Extracurricular Activities _____

_____

_____

Medical History

Do you have any the following conditions?

□ Pregnant □ Breast Feeding □ Arthritis □ Diabetes □ High Blood Pressure □ Scarring Keloid

□ Bronchitis □ Emphysema □ Asthma □ Shortness of Breath □ Heart Attack □ Chest Pain

□ Pacemaker □ Thyroid □ Bladder/Kidney □ Hepatitis/Jaundice □ HIV/AIDS

□ Smoke if **YES**, how much _____ packs per day _____years

□ Other_____

Height _____ Weight _____

Please list any **medications** you are currently taking, Including eye drops

_____

_____

Have you taken Accutane or a derivative of it? _____

Allergic to any medications _____

List any previous eye conditions, eye injuries, eye surgeries_____

_____

Glasses or Contacts

Do you currently wear □ Glasses □ Contacts

If Contact Lenses, what kind? □ Soft Daily Wear □ Soft Extended Wear □RGP(hard)

Do you wear your contacts over night? □ No □ Yes, how long? _____

How many years have you worn contacts or glasses? _____

When was your last eye exam? _____

What prompted you to come in? _____

_____

Do you have any problems with glasses or contacts?

□ Poor Comfort □ Poor Cosmetic Appearance □ Tired of Having Poor Vision

□ Nuisance □ Limits Enjoyment of Activities □ Safety/Security

□ Dependence □ Restricts my Physical Activities □ Poor Peripheral Vision

Refractive Evaluation Patient History

Are you on the Atkins or other diet program?	Yes	No	Do you use recreational drugs?	Yes	No
Do you have amblyopia or have only one functional eye?	Yes	No	Are you immunosuppressed from medications or have AIDS?	Yes	No
Do you have or have you had Herpes Simplex or Herpes Zoster involving your eyes?	Yes	No	Do you have any problems with anesthesia?	Yes	No
Do you have Keratoconus?	Yes	No	Have you taken Steroids in the last 2 months?	Yes	No
Diagnosed with Glaucoma?	Yes	No	Do you drink alcoholic beverages?	Yes	No

On a Scale from 1 to 5, Please Indicate How Important the Following:

	Least	Not Very	Somewhat	Very	Most
Safety of Procedure	1	2	3	4	5
Experience of Doctor	1	2	3	4	5
Cost/Expense	1	2	3	4	5
Long-Term Studies	1	2	3	4	5
Financing	1	2	3	4	5
Not interfering with lifestyle	1	2	3	4	5
Talking to former patients	1	2	3	4	5

How did you hear about us?

□ Internet/Website_____ □ Radio □ Friend _____ □ Employee _____

□ Relative _____ □Other _____ □ Doctor _____

REFRACTIVE CONSULTATION

PATIENT ACKNOWLEDGEMENT AND CONSULTATION WAIVER

I, _____, hereby acknowledge I understand and accept the following policies as outlined by the Hodges Eye Care & Surgical Center.

I hereby give my consent to the staff and doctors of Hodges Eye Care & Surgical Center to perform a **free** refractive evaluation and consultation today.

I understand today's evaluation is **free** and that It SHOULD NOT BE CONSIDERED A "COMPREHENSIVE EYE EXAMINATION" I further understand all testing and findings accumulated today are for CONSULTATION PURPOSES ONLY.

By signing below, I agree to accept the above policies. I hereby release and hold harmless Hodges Eye Care & Surgical Center from any liability associated with today's refractive consultation.

If I proceed and schedule my procedure, then I choose not to proceed I understand I will be held responsible for the fees of the exam conducted by the doctor. The only time these fees will be waived is if I am found to not be a good candidate for a refractive surgical procedure.

Fees for the preoperative exam will be $150.

_____

Signature of Patient

_____

Print Name

_____

Today's date