TraversLasik
VISION CARE

Patient Registration

Name: _____ Date of Birth: _____ Age: _____
(First) (Middle) (Last)

Address: _____ City: _____ State: _____ Zip: _____

Email Address _____ Cell Phone ( ) _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Ext: _____

Patient Preferred Name: _____ Patients Sex: ____Male ____Female Marital Status: S M W D

Employer: _____ Occupation _____

Alternate/Emergency Name & Phone #: _____ ( ) _____

By providing this information you are consenting for us to contact you via these methods

1. How did you hear about Travers Lasik Vision Care? _____
2. Have you been or do you plan to visit any other laser vision correction providers? ☐ Y ☐ N If yes, how many? _____
3. What is your biggest concern about having vision correction surgery? _____
4. What problems, if any, are you currently having in your contacts or glasses? _____
5. What is motivating you to get rid of your glasses/contacts? (reading/sports/work/kids) _____
6. Will you be using funds from an employer sponsored flexible spending plan towards the procedure? ☐ Y ☐ N
7. How soon would you like to have your laser vision correction? ___ASAP ___1-4 weeks ___1-3 months ___ >3 months
8. Have you read online or heard anything about LASIK that you would like the doctor to discuss? ☐ Y ☐ N

If yes, please explain: _____

Eye History

1. Do you primarily wear: ☐ Glasses ☐ Contacts Lenses?
   - Who prescribed them? _____ How long have they been your provider? _____
2. I wear vision correction for: ☐ Reading ☐ Distance ☐ Both
3. Do your glasses have prism in them? ☐ Yes ☐ No (prism is used to correct double vision)
4. What type of contact lenses do you wear? ☐ Soft ☐ Toric for astigmatism ☐ RGP Average wear: _____
5. Do you sleep in your contact lenses? ☐ Yes ☐ No

6. Have you ever had any prior surgery/laser treatments to your eye (s)? If yes, please describe: ***Which eye?***: _____

What Procedure? _____ ***When***: _____

Where? _____ ***Doctor***: _____

7. Have you ever had an eye trauma (i.e. Scratched cornea, something lodged in an eye, etc.)? If yes, please describe: ___

_____

8. Have you ever been diagnosed with an eye condition / disease? (i.e. keratoconus, Sjögren's syndrome, glaucoma, dry eye strabismus, lazy eye as a child, etc.)? If yes, please describe: _____

Tech Initials_____ Doctor Initials_____

9. Are you currently using any eye medications? If yes, please list: _____

_____

10. Is there any family history of keratoconus, corneal diseases or blindness? If yes, please describe and note the relation to the individual: _____

Medical History

Do you or have you ever been treated for the following:

Y N

☐☐ Collagen, autoimmune, or immunodeficiency disease (e.g. Arthritis (Rheumatoid not Osteo , Lupus)
If yes, what disease? _____ When were you diagnosed? _____
Who is your treating physician? _____ May we contact this doctor? _____
Do you take an Immunosuppressant medication for this condition? Y N If yes, what? _____

☐☐ Show signs of keratoconus (a corneal disease) or have any other condition that causes thinning of your cornea

☐☐ Herpes eye infections

☐☐ Double vision

Are you **CURRENTLY** Pregnant or Nursing? ☐ Yes ☐ No * If Yes: How many times per day? _____
When do you plan on stopping? _____

1. List all medical conditions you are **currently** being treated for: _____

_____

2. List all surgeries you have had: _____

_____

Do you or have you ever been treated for– (check only those that apply)

☐ Diabetes type 1 ☐ Diabetes type 2 → If so, how long? _____ Are you using Insulin? _____
☐ Pace maker ☐ Heart disease ☐ Heart attack ☐ by-pass surgery
☐ Stroke ☐ High blood pressure ☐ Neurological Disorders ☐ Lung Problems
☐ Seizures ☐ Prostate disease ☐ Bleeding disorders ☐ Liver disease
☐ Hepatitis B or C ☐ Kidney stones or infection ☐ Rheumatic disorders ☐ HIV
☐ Ulcers ☐ Stomach Problems ☐ Sinus problems
☐ Cancer or tumor, Type: _____ ☐ Other _____

Medications

List all medications that you are **ALLERGIC** to (I.e. latex, iodine, valium, antibiotics, steroids, etc.) If yes, please list : _____

_____

List all medications and **dosages** that you are **CURRENTLY** taking, including all over the counter meds: _____

_____

_____

_____ _____

Signature of Patient Date Tech Initials_____ Doctor Initials_____

Patient Name: _____ DOB:_____

If you wear glasses or contacts then answer questions relevant to when you are wearing your glasses or contacts.

Ocular Surface Disease Index® (OSDI®)[2]

Ask your patient the following 12 questions, and circle the number in the box that best represents each answer. Then, fill in boxes A, B, C, D, and E according to the instructions beside each.

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING *DURING THE LAST WEEK*:

	All of the time	Most of the time	Half of the time	Some of the time	None of the time
1. Eyes that are sensitive to light?	4	3	2	1	0
2. Eyes that feel gritty?	4	3	2	1	0
3. Painful or sore eyes?	4	3	2	1	0
4. Blurred vision?	4	3	2	1	0
5. Poor vision?	4	3	2	1	0

Subtotal score for answers 1 to 5 ( )

HAVE PROBLEMS WITH YOUR EYES LIMITED YOU IN PERFORMING ANY OF THE FOLLOWING *DURING THE LAST WEEK*:

	All of the time	Most of the time	Half of the time	Some of the time	None of the time	
6. Reading?	4	3	2	1	0	N/A
7. Driving at night?	4	3	2	1	0	N/A
8. Working with a computer or bank machine (ATM)?	4	3	2	1	0	N/A
9. Watching TV?	4	3	2	1	0	N/A

Subtotal score for answers 6 to 9 ( )

HAVE YOUR EYES FELT UNCOMFORTABLE IN ANY OF THE FOLLOWING SITUATIONS *DURING THE LAST WEEK*:

	All of the time	Most of the time	Half of the time	Some of the time	None of the time	
10. Windy conditions?	4	3	2	1	0	N/A
11. Places or areas with low humidity (very dry)?	4	3	2	1	0	N/A
12. Areas that are air conditioned?	4	3	2	1	0	N/A

Subtotal score for answers 10 to 12 ( )

ADD SUBTOTALS A, B, AND C TO OBTAIN D (D = SUM OF SCORES FOR ALL QUESTIONS ANSWERED) ( )

TOTAL NUMBER OF QUESTIONS ANSWERED (DO NOT INCLUDE QUESTIONS ANSWERED N/A) ( )

Please turn over the questionnaire to calculate the patient's final OSDI® score.

TraversLasik
VISION CARE

RELEASE REQUEST OF MEDICAL INFORMATION
TRAVERS LASIK VISION CARE

_____ **DOB:**_____

(Please print your name above – First, Middle, Last)

Dr. Travers may require a copy of your previous records to provide you the best possible care.

I authorize: _____

(Please print above – Your Eye Doctor's Name and/or Practice Name)

City/State/Zip: _____

Phone: ( ) _____

Fax: ( ) _____

To release **ALL medical records** pertaining to my health / eye examinations including but not limited to:

- **Minimum 2-3 FULL Exams (If Available)**
  More may be requested, if needed
- **Refraction with Visual Acuity**
- **Keratometry**
- **Autorefractor Tape or Data**
- **Ocular / Systemic Health**
- Other: _____

Please submit to:

Travers Lasik Vision Center
2501 Atrium Drive, Suite 200
Raleigh, NC 27607
Phone# (919)510-6830
Fax# (919)510-6835

_____

Patient Signature Date

_____

Staff Signature