EYE CONSULTANTS
OF BONITA SPRINGS, PLLC

LASIK Checklist

NAME _____

YES	NO	Without glasses or contact lenses….
☐	☐	Do you have trouble seeing at distance?
☐	☐	Do you have trouble seeing up close?
☐	☐	Do you have night vision problems? If yes, please describe: _____
☐	☐	Do you have dry eye problems? If yes, please describe: _____
☐	☐	Are you pregnant or nursing?
☐	☐	Do you have severe diabetes or severe allergies?
☐	☐	Do you have any active eye diseases, for example glaucoma or cataracts?
☐	☐	Do you have collagen vascular, autoimmune or immunodeficiency diseases (for example: Rheumatoid arthritis, Lupus, AIDS)?
☐	☐	Do you show signs of keratoconus (corneal disease)?
☐	☐	Would you be satisfied if your natural vision was greatly improved even if you still had to wear corrective lenses some of the time?
☐	☐	Do your glasses or contacts interfere with your recreational activities? If yes, which activities: _____
☐	☐	Do you feel that good vision without glasses is more important to you than perfect vision with glasses?
☐	☐	Is it acceptable to you that you may need glasses for reading after LASIK?
☐	☐	Do you have vision problems with reading or computer work? If yes, please describe: _____
☐	☐	Do you have vision issues, limitation, or restrictions with your work or profession? If yes, please describe: _____