INSIGHT VISION GROUP

Name:____ Date: ____________________________

LIFESTYLE Questionnaire:

1. What is your occupation? ____

2. What are your favorite hobbies? ____

3. Do you do a lot of close detail work such as: sewing/knitting/drawing/etc.? ☐ Yes ☐ No

4. How do you feel about wearing glasses? (please check all that apply)
   ______ I don't mind wearing glasses all day.
   ______ I don't mind wearing glasses for reading/close work.
   ______ I don't mind wearing glasses for TV/driving distances.
   ______ I would like to greatly reduce dependence on glasses for both reading and far distance.

5. Have you ever tried monovision with contact lenses/glasses? ☐ Yes ☐ No

6. Does your vision effect your ability to read or perform computer work? ☐ Yes ☐ No

7. Would you be content knowing you may require glasses for some tasks? ☐ Yes ☐ No

8. Do you consider yourself to be an easy-going person and adaptable to change? ☐ Yes ☐ No

9. How did you hear about us?
   _____ Eye Doctor ______________________________
   _____ Internet
   _____ Friend/Family Member ______________________________
   _____ Saw our signage

10. Do you have an email you would like to share with us? ☐ Yes ☐ No

    If Yes, please provide:____

~Do you have vision insurance?.~ ☐ Yes ☐ No

If yes, please provide:______________________________

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please Print):

Name: ___________________________Date of Birth: ___/____/_____

Address: ____

City: ________________________ State: ________ Zip: _____________

Home Phone: (_____)______-_______ Cell: (_____)______-_______

RELEASE MY MEDICAL RECORDS FROM:

OPTOMETRIST INFORMATION (Please Print):

____

____

____

____

RELEASE MY MEDICAL RECORDS TO:

InSight LASIK South ____ 11961 Lioness Way Parker, CO 80134
Phone: 720-880-6455 Fax: 720-880-6460

InSight LASIK North ____ 4430 Arapahoe Avenue Suite 155 Boulder, CO 80303
Phone: 303-402-1000 Fax: 303-593-2199

BY MY SIGNATURE, I AUTHORIZE RELEASE OF MY MEDICAL RECORDS – including, but not limited to, progress notes, operative notes, laboratory results, and diagnostic tests.

Patient Signature: _________________________________ Date: __________

INSIGHT VISION GROUP

To be completed by patient or family:

Name:______________________________ Age :__________ **Date**:__________________________

Chief Problem:____

Referred by:________________________________ Phone:________________________________

Known Eye Problems:	Onset	R	L	**Previous Eye Surgery:** Right Eye	Left Eye
Cataracts________	______	___	___	______	______
Injury________	______	___	___	______	______
Farsighted/Nearsighted ____	______	___	___	______	______
Lazy Eye ________	______	___	___	______	______
Retinal Disease ______	______	___	___	______	______
Corneal Disease______	______	___	___	______	______
Glaucoma________	______	___	___	______	______

Present Eye Medications:

List all **Allergies** Below:

Name (circle below):	Year Started	Which Eye(s)	How often?	Used Before?	Allergies
Alphagan (P)/Brimonidine	______	R L Both	1 2 3 4	Y N	______________
Azopt	______	R L Both	1 2 3 4	Y N	______________
Betagan (levobunolol)	______	R L Both	1 2 3 4	Y N	______________
Betaxolol or Carteolol	______	R L Both	1 2 3 4	Y N	______________
Combigan	______	R L Both	1 2 3 4	Y N	______________
Cosopt	______	R L Both	1 2 3 4	Y N	______________
Diamox or Neptazane Pill	______	______mg	1 2 3 4	Y N	______________
Dipivefrin (Propine)	______	R L Both	1 2 3 4	Y N	______________
Doxycycline Pill	______	______mg	1 2 3 4	Y N	______________
Lumigan	______	R L Both	1 2 3 4	Y N	______________
Ocupress/OptiPranolol	______	R L Both	1 2 3 4	Y N	______________
Ointment: ______	______	R L Both	1 2 3 4	Y N	______________
Pilocarpine (GEL?)	______	R L Both	1 2 3 4	Y N	______________
Restasis:	______	R L Both	1 2 3 4	Y N	______________
Steroid Eye Drop	______	R L Both	1 2 3 4	Y N	______________
Timoptic/timolol	______	R L Both	1 2 3 4	Y N	______________
Travatan	______	R L Both	1 2 3 4	Y N	______________
Xalatan	______	R L Both	1 2 3 4	Y N	______________
Vigamox/Zymar	______	R L Both	1 2 3 4	Y N	______________
Other:	______	R L Both	1 2 3 4	Y N	______________
Other:	______	R L Both	1 2 3 4	Y N	______________

Visual Symptoms:

Do you have trouble reading?	Y	N	Sudden Visual loss?	Y	N
Can you read small print?	Y	N	Gradual Vision Loss?	Y	N
Can you read large print?	Y	N	Night Blindness?	Y	N
Can you recognize people?	Y	N	Double Vision?	Y	N
Can you see steps?	Y	N	Halos?	Y	N
Can you read signs?	Y	N	Sensitivity?	Y	N
Can you see to do fine handwork?	Y	N	Eye Pain?	Y	N
Can you see to write checks?	Y	N	Headaches?	Y	N
Can you see to play table games?	Y	N	Eyes Itch?	Y	N
Can you see to play sports?	Y	N	Other Eye Symptoms:		
Can you see to cook?	Y	N	Highest Eye Pressure & Date:		
Trouble watching TV?	Y	N			
Currently Drive?	Y	N	Dr. Comments:		

***Medical History on other side:

Active Medical Problems: (Please check all that apply)

- Asthma
- Diabetes
- High blood pressure
- Heart disease
- Stroke
- Migraines
- TB
- Hepatitis
- HIV
- Seizures
- Blood disorder
- Psychiatric condition
- Nervous condition
- Temporal arteritis
- Arthritis
- Skin disorder

Social History

Do you smoke?	Y	N
Do you drink alcohol?	Y	N
Any occupational hazard exposure?	Y	N

Current General Medications:

____
____
____
____
____
____
____
____
____
____
____

Other Medical and Surgical History: Please write out problems and year it occurred:

____
____
____
____
____

Family History: (please check all that apply and note whom was affected: F=Father M=Mother S=Sister B=Brother C=Child A=Aunt U=Uncle GP=Grandparent O=Other)

()	Glaucoma	____________________	()	Diabetes	____________________
()	Cataracts	____________________	()	Heart	____________________
()	Corneal disease	____________________	()	Stroke	____________________
()	Retinal disease	____________________	()	Cancer	____________________
()	Similar problem	____________________	()	Other	____________________

System Review: (circle symptoms that apply to you)

General:	fatigue	weight loss	fevers	chills	tired	
Skin:	rash	blisters	dry patches	spots		
Nose, Ears and Throat:	nasal drip	sinus infections	poor hearing	sore throat	dry mouth	missing teeth
Heart:	palpitations	chest pain	short of breath	sleep with head elevated	irregular heart beat	
Lungs:	cough	wheezing	gasping	pneumonia		
Abdomen:	stomach pain	diarrhea	bleeding	pain	tenderness	
Muscles:	weak lifting arms or climbing steps	no strength				
Bones:	osteoporosis	joint pain	easy fractures			
Genito-urinary:	kidney stones	burning with urination	incontinence	pregnant		
Nervous system:	tremor	imbalance				