Associates in Ophthalmology
THE EYE SURGEONS
www.AIOeyesurgeons.com
#1-800-246-1000

Pre-Operative Evaluation Form

Co-managing Doctor: ____________________ Telephone #: ____________________

To be completed by patient:

Name ____ Date: ______________

Address ____

City ______________________________ State ________ Zip ______________

Telephone # (Home) ________________ Telephone# (Daytime) ______________

Date of Birth _____/______/_____ Social Security # ______-_____-______

Please state in your own words, your expectations for refractive surgery.

For Example: To wake up in the morning and see the alarm clock
To see my children at the pool

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____
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Do you have any medical problems? ______________________________

List all medications you are currently taking: ______________________________

Are you allergic to any medications? ______________________________

Do you have any history of eye problems? ______________________________

Do you currently wear contact lenses? Yes No

If yes, what type? (Circle one) Soft Hard Gas Permeable

How many hours a day do you wear them? ________ How many years? ________

Last date contacts were worn prior to this exam? ______________________________