Denise M. Visco M.D.
Jerome V. Benz, Jr. D.O

eyes of york

PATIENT INFORMATION SHEET

The following questions will help in determining what kind of candidate you will be for laser vision correction.

Name_____Date_____
Email Address_____
Sports/Hobbies/Interests_____
Profession_____

How were you referred to this practice? ___Newspaper ___Radio ___Internet ___Phone Book
___Mailer ___Doctor ___Other (*Name Radio Station/Newspaper/Doctor)_____
___Friend/Relative/Co-Worker (Name) _____

Date of last eye exam_____ How old are your current eyeglasses?_____
Current Eye Care Doctor_____
Has your prescription been stable for two years? Y or N
Do you wear glasses: ___Full time ___Part time ___Very little ___Never
Do you wear contacts: ___Full time ___Part time ___Very little ___Never
What type of contact lenses do you wear: ___Soft ___Soft Torics ___Gas Perm (RGP) ___Hard
Date that you last wore your contact lenses_____ Number of years worn_____

Please check those that apply to you:

Medical History
___Pregnant or nursing within the past 6 months
___Diabetes—type_____
___Sjogrens Syndrome
___Rheumatoid Arthritis
___Lupus
___Crohn's Disease
___Keloids
___Rosacea
___Pacemaker/Defibrillator

Ocular History
___Cataracts
___Retinal Disorders
___Dry Eyes
___Refractive Surgery
___Glaucoma
___Corneal Disease
___Corneal Scars
___Eye Condition/Injury/Surgery
_____

List any drug allergies:_____
List any medications you currently take: _____
_____
What problems are you having with your current system of vision correction?_____
_____

***I understand this is a refractive screening only and does not replace a full eye exam by an ophthalmologist or optometrist. This screening is educational only and does not fulfill the requirements of a diagnosis or treatment.

Patient_____Date_____