Jeffrey D. Horn, MD
*Vision for Life*

# 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?<br>If yes, please describe: _____ |
| ❑ | ❑ | Do you have dry eye problems?<br>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)? |
| ❑ | ❑ | Do you have Vision Insurance?<br>If yes, please provide Front Desk with Benefits card so that we may make a copy. |
| ❑ | ❑ | 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?<br>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?<br>If yes, please describe: _____ |
| ❑ | ❑ | Do you have vision issues, limitation, or restrictions with your work or profession? If yes, please describe: _____ |