# SURGERY ASSESSMENT FORM

Name: ______________________ Male ☐ Female ☐ Chart No.: ____________

Address: ______________________________________________
Number/Street City/Province Postal Code

Birthdate: ______________ email: ______________________

Phone: ______________ Mobile: ______________ Other: ______________

If from out of town, Winnipeg number where you can be reached: ______________

Employer: ______________ Occupation: ______________

Favourite hobbies, sports, etc.: ______________

Currently, do you wear: Eyeglasses ☐ Contacts ☐ Both ☐ How often? ______________

If you wear contacts: Hard ☐ Soft ☐ Hours/day: ________ Occasions/week: ________

When did you last wear contacts?: ______________

Do you suffer from:

| | | | |
|---|---|---|---|
| Night glare/halos around bright lights | ☐ | Dry eyes | ☐ |
| Eye allergies | ☐ | Intolerance to contacts | ☐ |

Goal post-surgery:

| | | | |
|---|---|---|---|
| No glasses at all | ☐ | Glasses sometimes | ☐ |
| Lighter prescription | ☐ | Enjoy sports more | ☐ |
| Job-related | ☐ | Cosmetic reason | ☐ |

Other (please specify): ______________

How did you hear about IMAGE PLUS: ______________

What is your biggest concern: ______________

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| **MEDICAL HISTORY:** | Yes | No |
|---|---|---|
| Diabetes | ☐ | ☐ |
| Collagen vascular disease | ☐ | ☐ |
| Auto-immune disease | ☐ | ☐ |
| Endocrine disease | ☐ | ☐ |
| Pregnancy/Breastfeeding: | ☐ | ☐ |
| Other: | ☐ | ☐ |

Comments: ______________

| **OCULAR HISTORY:** | Yes | No |
|---|---|---|
| Keratoconus | ☐ | ☐ |
| Injury | ☐ | ☐ |
| Previous surgery | ☐ | ☐ |
| Amblyopia | ☐ | ☐ |
| Glaucoma | ☐ | ☐ |
| Allergies | ☐ | ☐ |

Have you ever fainted at a medical appointment? Yes ☐ No ☐

Medications: (please list name, dosage, and reason): ______________

Date: ______________ Initial: ________