LASER EYE AND AESTHETICS

Laser Eye and Aesthetics

World-class vision and aesthetic care from your local specialists

P: (226) 884-2020

F: (226) 884-2021

www.lasereyeaesthetics.com

Patient Intake Form

Patient Name: DOB: Age:

Health Card #: Gender:

Address:

Phone: Cell: Work:

Email:

(I understand that by providing my email address I am giving Laser Eye and Aesthetics permission to contact me via email)

Current Optometrist: Referral source:

Emergency contact
Name: Relationship:

Phone:

Prescription Glasses/contact lens: Yes No Contact Lenses: Soft / Rigid Gas. Perm

Contacts last worn:

Any previous eye surgery/trauma/diagnosis:

Do you use any eye drops:

Do you have any allergies:

Do you drive: YES NO Occupation:

Hobbies:

LASER EYE AND AESTHETICS

Laser Eye and Aesthetics

World-class vision and aesthetic care from your local specialists

P: (226) 884-2020

F: (226) 884-2021

www.lasereyeaesthetics.com

Your Medical History (check all that apply to you)

Condition	YES	No	Describe please
Previous LASIK/PRK/RK/SMILE			
Lazy eye			
Previous Eye injury			
Previous Herpes or Shingles infection of the eye			
Keratoconus			
Glaucoma			
Macular degeneration			
Other eye condition			
Angina/Chest pain			
Congestive Heart Failure			
Irregular heart beats			
Coronary stents/bypass			
High blood Pressure			
Pacemaker			
Previous stroke/TIAs			
Asthma (inhaler use)			
COPD			
Smoker			
Sleep apnea			
Autoimmune disease (ex: rheumatoid arthritis)			
Diabetes			
Pregnancy			
Other			

LASER EYE AND AESTHETICS

Laser Eye and Aesthetics

World-class vision and aesthetic care from your local specialists

P: (226) 884-2020

F: (226) 884-2021

www.lasereyeaesthetics.com

Your current medications (please list all medications that you are taking)

Medication	Dose	How many times a day	Medication	Dose	How many times a day
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Anaesthesia history

Condition	YES	No	Describe please
Have you ever had a complication with anaesthesia?			
Have you or your blood relative ever had malignant hyperthemia?			

Please write down any other details that you would like your doctor to be aware of?

Your name (print): Date:

Signature: