



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?

If yes, please describe: _____

Do you have dry eye problems?

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)?

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?

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?

If yes, please describe: _____

Do you have vision issues, limitation, or restrictions with your work or profession?

If yes, please describe: _____