PATIENT DATA

Last Name:_____ First Name:_____

☐ Male ☐ Female Date of Birth_____ Age_____ IMW#_____

Address_____ City_____ State _____ Zip _____

Home Phone #_____ Work Phone #_____ Occupation_____

Email:_____ Insurance:_____

Emergency Contact Name_____ Phone#_____

Past Ocular History:

☐ None ☐ Cataracts ☐ Retinal Tear/Detachment ☐ Glaucoma
☐ Keratoconus ☐ Dry eyes ☐ Herpes Simplex/Zoster ☐ Eye Trauma
☐ Amblyopia/ Lazy Eye

Past Ocular Surgery:

☐ None ☐ Muscle ☐ Retinal ☐ PRK/LASIK ☐ AK/ALK
☐ Cataract

Contact Lens History:

☐ None ☐ Soft Daily Wear ☐ Soft Toric ☐ RGP/ PMMA

Do you sleep in your contacts? Yes ☐ No ☐ Date last worn: _____ Number of years worn: _____

Is there a family history of either of the following?

☐ Keratoconus ☐ Corneal Transplant If yes, what is the relation? _____

Have you taken any of the following medications within the past 6-months?

Topamax	☐ Yes ☐ No	Accutane	☐ Yes ☐ No
Imitrex	☐ Yes ☐ No	Amiodarone	☐ Yes ☐ No
Cordarone	☐ Yes ☐ No	Methotrexate	☐ Yes ☐ No
Prednisone	☐ Yes ☐ No		

Medication Allergies ☐ None List: _____

Other Medications Taken: ☐ None List: _____

General Health:

Arthritis	☐ Yes ☐ No	Lupus	☐ Yes ☐ No
Breast Feeding	☐ Yes ☐ No	Pregnant	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	HIV/Hepatitis	☐ Yes ☐ No
Keloid Scarring	☐ Yes ☐ No	Other: _____	

Most Recent Eye Doctor Seen: _____ Approx Date: _____

_____ I have been offered a copy of the Patient Information Booklet that is provided by the laser manufacturer.
Pt. Initials

_____ I have been offered a copy of SEI's Notice of Privacy Practices in compliance with HIPAA Regulations.
Pt. Initials

Patient Signature:_____ Date:_____

Print Name:_____ SEI Assistant:_____