Questionnaire - Preoperative

Name: First _____ Middle _____ Last _____

Nationality:_____ □ Male □ Female

Birthday: year /month /day Occupation:_____

Address:_____

May we send you direct mail that has our clinic's name on it? Yes ・ No

Phone (Home):_____ (Mobile):_____

Phone (Emergency):_____

May we use our clinic's name when contacting you by telephone? Yes ・ No

E-mail:_____

1. How did you find our clinic?

□ Magazines ( )
□ Newspapers ( )
□ Radio or television ( )
□ Website of Minamiaoyama Eye Clinic
□ Online search (Yahoo, Google, others)
□ Introduced by a friend (Name:)
□ Referred by an eye clinic or a hospital (Name:)
□ Others ( )

2. Contact lens history

Do you wear contact lenses?

□ No, I don't. (If no, then go to number 3.)
□ Yes, I do. ①Hard ②Soft for astigmatism ③Multifocal
④Soft regular / disposable (1DAY ・ 1WEEK ・ 2WEEK ・ 1MONTH)
How many years have you been wearing contact lenses? For year(s).

If yes, are you wearing them now?

□ Yes, I am.
□ No, I'm not.

If no, how many days haven't you been wearing them? For day(s).

3. Please indicate why you would like to have refractive surgery.

□ Professional reason ( )
□ Cosmetic reason
□ Glasses or contact lenses are inconvenient when playing sports or doing hobbies
□ Anisometropia (Right and left eye power are different.)
□ Tired of wearing (thick) glasses
☐ Red eye or foreign body sensation with long time use of contact lenses
☐ Troublesome contact lens care
☐ Glasses or contact lenses are expensive
☐ Want to live without glasses or contact lenses

4. Please check your preoperative eye condition.

		No	Mild	Moderate	Severe
Eye fatigue	Right eye	□	□	□	□
	Left eye	□	□	□	□
Brightness	Right eye	□	□	□	□
	Left eye	□	□	□	□
Dryness	Right eye	□	□	□	□
	Left eye	□	□	□	□
Foreign body sensation	Right eye	□	□	□	□
	Left eye	□	□	□	□
Itchiness	Right eye	□	□	□	□
	Left eye	□	□	□	□
Red eye	Right eye	□	□	□	□
	Left eye	□	□	□	□
Discharge	Right eye	□	□	□	□
	Left eye	□	□	□	□

If you have any other eye symptoms, please describe. _____

_____

If you have any medical trouble with glasses or contact lenses, please indicate.

☐ Red eye and/or pain with contact lenses
☐ Eye fatigue and/or pain from glasses
☐ Contact lenses are not permitted by your doctor
☐ Others ( )

(General symptoms)

Headache	□ No	□ Mild	□ Moderate	□ Severe
Stiff shoulders	□ No	□ Mild	□ Moderate	□ Severe
Nausea	□ No	□ Mild	□ Moderate	□ Severe

5. Please inform us of your medical history, including past surgeries or major illnesses.

☐ Diabetes mellitus (DM) □ Hypertension □ Hepatitis □ Blood transfusion
☐ Others:

6. Are you taking any medications?

Eyedrops:
Medicine:
Injections:

7.□allergy(medication・food)・seasonal( )