AUSTIN EYE
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REFRACTIVE SURGERY QUESTIONNAIRE

NAME:________________________ DATE:_____________ OCCUPATION:________________________

1 WHAT HOBBIES/ACTIVITIES ARE YOU MOTIVATED TO BE ABLE TO DO AFTER SURGERY WITHOUT DEPENDENCE ON GLASSES OR CONTACT LENSES?

2 DO YOU UNDERSTAND THAT INDIVIDUALS OLDER THAN 40 YEARS OF AGE WILL EVENTUALLY NEED “READING GLASSES” TO SEE CLEARLY UP-CLOSE?

   Please circle one:      YES     NO

3 IF YOU ARE OLDER THAN 40, HOW WOULD YOU FEEL IF YOU HAD TO USE READING GLASSES TO READ THE NEWSPAPER OR TO WORK AT THE COMPUTER AFTER SURGERY?

4 IF YOU ARE OLDER THAN 40, WOULD YOU BE WILLING TO WEAR GLASSES TO READ OR WORK AT THE COMPUTER (CIRCLE ONE):

   a. All the time
   b. Some of the time
   c. Never

5 DO YOU SEE GLARE AND/OR HALOES AROUND LIGHTS AT NIGHT? YES / NO

   a. If yes to question 5, is your night glare mild, moderate or severe (please choose one).

6 WHAT ARE YOUR EXPECTATIONS FROM LASER CATARACT SURGERY OR LASER VISION CORRECTION?

7 HAVE YOU EVER TRIED MONOVISION (ONE EYE FOCUSES NEAR AND THE OTHER FOCUSES FAR AWAY)?

   Please circle one:      YES     NO

8 IF YES TO THE ABOVE QUESTION, DID YOU LIKE MONOVISION?

   Please circle one:      YES     NO

9 HAVE YOU REVIEWED OUR WEBSITE: WWW.AUSTINEYE.COM?

   Please circle one:      YES     NO

10 DO YOU WEAR SOFT CONTACTS?

   Please circle one:      YES     NO

11 IF YES, DO YOU SLEEP IN YOUR CONTACT LENSES? YES       NO

12 HOW OFTEN DO YOU REPLACE EACH PAIR OF SOFT CONTACT LENSES? Please circle:

   Every day    weekly      every 2 weeks every month every 3 months yearly other________

13 WHAT ARE YOUR MAIN CONCERNS/QUESTIONS ABOUT SURGICAL VISION CORRECTION?

14 HOW DID YOU HEAR ABOUT OUR OFFICE? WHY DID YOU CHOOSE TO COME TO SEE OUR DOCTORS?

15 HAVE YOU EVER HAD ANY PREVIOUS EYE SURGERY, EYE INFECTION, OR EYE INJURY? IF SO, PLEASE DESCRIBE:

16 IF THE SURGEON INFORMS YOU THAT YOU ARE A GREAT CANDIDATE FOR VISION CORRECTION SURGERY WHEN WOULD YOU LIKE TO HAVE YOUR VISION CORRECTED?