Slade & Baker Vision Screening Form

Please fill out the **top portion** and the **back** of this sheet.

Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Cell Phone _____ Work Phone _____

Date of Birth _____ Age _____ Email Address _____

Date of Last Eye Exam _____

▸ How did you hear about our clinic? (Please check one)

☐ Newspaper ☐ Search engine ☐ Other Internet: (Address _____)
☐ TV ☐ Radio ☐ Past Patient: (_____)
☐ Vision Insurance: (_____) ☐ Other _____
☐ Optometrist: (_____)

▸ What corrective lenses are you currently wearing?

☐ Glasses ☐ Soft Daily Wear ☐ Soft Overnight Wear Contacts
☐ Soft Toric Contacts ☐ RGP Contacts ☐ Hard (PMMA) Contacts

▸ The next step of your screening is to have a full eye exam. Your eye exam is required at least 24 hours before your surgery date and you must be out of your contact lenses.

☐ If possible, I would like to have my exam today. ***(The cost for an exam is $300.00)***
☐ I will schedule my eye exam on a later date.

For office use only below.

Candidate for SX? _____ Type of SX? ☐ LASIK ☐ PRK ☐ SMILE ☐ ICL ☐ CLE

Both eyes treated same day? ☐ Yes ☐ No

OHX: _____
Allergies: _____
Meds: _____
Dom: _____

Do they wear contacts? ☐ Yes ☐ No
If so: What kind? _____

Visual Stability (yrs): _____

W OD:
OS:

Va 20/20

CC, SC, CCL

Pupils
OD
OS

Near vision
SC/CC/Readers only
OD: J__
OS: J__

Pentacam
OD:
OS:

Lipiscan
OD:
OS :

Amsler

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SLADE & BAKER VISION

Refractive Checklist

Name _____

Yes	No	
☐	☐	Do you have trouble with distance vision?
☐	☐	Do you have trouble seeing up close?
☐	☐	Do you wear reading glasses for close work? If yes, how many years have you been wearing them? _____
☐	☐	Do you have night vision problems? If yes, please describe: _____
☐	☐	Do you have dry eyes? If yes, please describe: _____
☐	☐	Are certain or hobbies you're interested in compromised by your near vision? If yes, please describe: _____
☐	☐	Do you have severe diabetes or severe allergies?
☐	☐	Are you pregnant, breastfeeding, or planning to be pregnant soon?
☐	☐	Do you have any active eye disease, for example glaucoma, cataracts, or health problems such as: collagen, vascular, autoimmune, or immunodeficiency diseases (for example: Rheumatoid, Lupus, AIDS)? If yes, please describe: _____

Would you be satisfied with a procedure that allows you to function in a daily life without reading glasses, but still require you to use them for prolonged close work? _____

What type of work do you do? _____

How many hours per day do you spend on the computer? _____

How many hours per day do you spend reading, either for business or for pleasure? _____

Describe any vision issues that occur when driving: _____