Keratoconus questionnaire

1. Have you been diagnosed with keratoconus? Y / N If so, when? ____________(date)

2. Have you had LASIK or PRK? Y / N If yes, please circle: both eyes, right eye, Left eye

3. Have anyone else in your family been diagnosed with keratoconus? Y / N if so please list relationships: ______________________________________________________________________________________________

4. Have you or any of your family members been diagnosed with connective tissue disorders such as Marfan Syndrome, Loeys-Dietz syndrome, Ehlers-Danlos syndrome, or Familial Thoracic Aortic Aneurysm and Dissection? Y / N If yes please list: ______________________________________________________________________________________________

5. Do you or any of your family members have hypermobile joints, frequent joint dislocations or soft velvety easily stretched skin? Y / N If yes please describe: ______________________________________________________________________________________________

6. Have you ever been diagnosed with herpetic eye infection? Y / N If yes, which eye? R / L

7. Please place a check by any/all of the following symptoms you’ve experienced:
   ____ a history of declining vision
   ____ contact lens intolerance
   ____ visual distortion
   ____ difficulty driving at night
   ____ glare
   ____ halos around lights
   ____ light sensitivity
   ____ eye strain
   ____ ghosting
   ____ excessive eye rubbing
   ____ cloudy vision
   ____ blurred vision
   ____ double vision
   ____ frequent changes in eye glass prescription or contacts
   ____ inability to obtain adequate vision with glasses

PATIENT SIGNATURE________________________________________

PATIENT NAME________________________________ DATE____________________

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