BAYAREA EYE INSTITUTE

KERATOCONUS QUESTIONNAIRE

1.Have you been diagnosed with keratoconus, post RK or post Lasik ectasia? Y/N. If so, Please circle the diagnosis above and list date of diagnosis _____ (date).

2.Have you had LASIK, PRK, RK, SMILE procedure?If Yes Please circle procedure.

Please circle: Both eyes, right eye, left eye. Procedure date: _____.

3.Has anyone else in your family been diagnosed with keratoconus? Y/N.

Please list relationship(s):_____

4.Do you have a history of asthma, eczema or hay fever Y/N please circle condition(s)

5.Have you or 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/or dissection? Y/N. If yes please circle which diagnosis

6.Do you or your family members have hypermobile joints, frequent joint dislocations or soft, velvety, easily-stretched skin? Y/N Please circle which ones(s)

7.Have you ever been diagnosed with a herpetic eye infection? Y/N. which eye? R/ L

8.Please place a check by any/all of the following symptoms you have experienced:

_____ A history of declining vision
_____ Visual distortion
_____ Glare
_____ Light sensitivity
_____ Ghosting
_____ Cloudy vision
_____ Double vision
_____ Inability to obtain adequate vision with eyeglasses
_____ Contact lens intolerance
_____ Difficulty driving at night
_____ Halos around lights
_____ Eyestrain
_____ Excessive eye rubbing
_____ Blurred vision
_____Frequent changes in prescriptions?

9.Eyeglass or contact lens prescription changed within the last two years? Y/N.

PATIENT'S SIGNATURE: _____

PATIENT NAME: _____

DATE: _____

_____ _____

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