BAYAREA EYE INSTITUTE

KERATOCONUS QUESTIONNAIRE

1. Have you been diagnosed with keratoconus? Y/N. If so, when? _____(date).
2. Have you had LASIK, PRK, RK, SMILE procedure? Yes/No. Please circle.
   Please circle: Both eyes, right eye, left eye. Procedure: _____.
3. Has anyone else in your family been diagnosed with keratoconus? Y/N.
   Please list relationships_____
4. Do you have a history of asthma, eczema or hay fever? Y/N please circle condition
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. please circle which one
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	_____ Contact lens intolerance
_____ Visual distortion	_____ Difficulty driving at night
_____ Glare	_____ Halos around lights
_____ Light sensitivity	_____ Eyestrain
_____ Ghosting	_____ Excessive eye rubbing
_____ Cloudy vision	_____ Blurred vision
_____ Double vision	_____Frequent changes in prescriptions?
_____ Inability to obtain adequate vision with eyeglasses	

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

PATIENT'S SIGNATURE: _____

PATIENT NAME: _____

DATE: _____

_____

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