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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