Do you notice any glare or halos at nighttime?
(Seen as rings or reflections around streetlights or headlights) ___ Yes ___ No

Is your nighttime vision worse than your daytime vision? ___ Yes ___ No

Have you ever been turned down for laser vision correction? ___ Yes ___ No

Do your eyes feel dry? ___ Yes ___ No

Do you find yourself frequently rubbing your eyes? ___ Yes ___ No

Are you taking any steroid medications? ___ Yes ___ No

Are you taking any antihistamine medications? ___ Yes ___ No

Are you taking any antidepressant medications? ___ Yes ___ No

Are you a 1st Responder? (Active Military, Police, Firefighter or EMT) ___ Yes ___ No

Female Patients: Are you pregnant or nursing? ___ Yes ___ No

So we may honor your privacy:
May we leave a message at your home or cell number? ___ Yes ___ No
May we leave a message at your work number? ___ Yes ___ No
May we discuss your medical condition with a family member? ___ Yes ___ No

If yes, name of family member:_______________________________ Relationship_____________

How were you referred to UVA LASIK?____

Did you research Dr. Odrich online? ___ Yes ___ No

If yes, would you share with us which resources you used and the keywords used:

Google
Bing
Yahoo
Twitter
Facebook
Instagram
SnapChat

Top Doctors America (Castel Connolly)
U.S. News Health
UVAHealth.com
Healthgrades.com
UVALASIK.com

Keywords used:______________________________________

Patient Signature____ Date:_____________

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