

AUSTIN EYE CLINIC
MITCHEL WONG, M.D. SHANNON M. WONG, M.D.
REFRACTIVE SURGERY QUESTIONNAIRE

NAME: _____ **DATE:** _____

- 1 WHAT HOBBIES/ACTIVITIES ARE YOU MOTIVATED TO BE ABLE TO DO AFTER SURGERY WITHOUT DEPENDENCE ON GLASSES OR CONTACT LENSES?**

- 2 DO YOU UNDERSTAND THAT INDIVIDUALS OLDER THAN 40 YEARS OF AGE WILL EVENTUALLY NEED "READING GLASSES" TO SEE CLEARLY UP-CLOSE?**
Please circle one: **YES** **NO**
- 3 IF YOU ARE OLDER THAN 40, HOW WOULD YOU FEEL IF YOU HAD TO USE READING GLASSES TO READ THE NEWSPAPER OR TO WORK AT THE COMPUTER AFTER SURGERY?**

- 4 IF YOU ARE OLDER THAN 40, WOULD YOU BE WILLING TO WEAR GLASSES TO READ OR WORK AT THE COMPUTER (CIRLCE ONE):**
a. All the time b. Some of the time c. Never
- 5 DO YOU SEE GLARE AND/OR HALOES AROUND LIGHTS AT NIGHT? YES / NO**
a. If yes to question 5, is your night glare mild, moderate or severe (please choose one).
- 6 WHAT ARE YOUR EXPECTATIONS FROM REFRACTIVE SURGERY/LASER VISION CORRECTION?**

- 7 HAVE YOU EVER TRIED MONOVISION (ONE EYE FOCUSES NEAR AND THE OTHER FOCUSES FAR AWAY)?**
Please circle one: **YES** **NO**
- 8 IF YES TO THE ABOVE QUESTION, DID YOU LIKE MONOVISION?**
Please circle one: **YES** **NO**
- 9 HAVE YOU REVIEWED OUR WEBSITE: WWW.AUSTINEYE.COM?**
Please circle one: **YES** **NO**
- 10 DO YOU WEAR SOFT CONTACTS?** Please circle one: **YES** **NO**
- 11 IF YES, DO YOU SLEEP IN YOUR CONTACT LENSES?** **YES** **NO**
- 12 HOW OFTEN DO YOU REPLACE EACH PAIR OF SOFT CONTACT LENSES? Please circle:**
Every day weekly every 2 weeks every month every 3 months yearly other _____
- 13 WHAT ARE YOUR MAIN CONCERNS/ QUESTIONS ABOUT SURGICAL VISION CORRECTION?**

- 14 HOW DID YOU HEAR ABOUT OUR OFFICE? WHY DID YOU CHOOSE TO COME TO SEE OUR DOCTORS?**

- 15 HAVE YOU EVER HAD ANY PREVIOUS EYE SURGERY, EYE INFECTION, OR EYE INJURY? IF SO, PLEASE DESCRIBE:**