

Vermont Laser Vision at Timber Lane

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PATIENT SYMPTOM QUESTIONNAIRE

Patient Name: _____ Date: _____

Patient Instructions: Please check the appropriate box to rate your symptoms, if any, that you may be experiencing for each of the following categories of potential eye and vision symptoms.

Symptom	Your Personal Experience				
Light Sensitivity	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Marked	<input type="checkbox"/> Severe
Headaches	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Marked	<input type="checkbox"/> Severe
Eye Pain Upon Awakening	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Marked	<input type="checkbox"/> Severe
Eye Pain During the Day	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Marked	<input type="checkbox"/> Severe
Redness	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Marked	<input type="checkbox"/> Severe
Dry Eye	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Marked	<input type="checkbox"/> Severe
Excessive Tearing	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Marked	<input type="checkbox"/> Severe
Burning	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Marked	<input type="checkbox"/> Severe
Gritty Feeling	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Marked	<input type="checkbox"/> Severe
Glare	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Marked	<input type="checkbox"/> Severe
Halos Around Lights	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Marked	<input type="checkbox"/> Severe
Blurry Vision	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Marked	<input type="checkbox"/> Severe
Double Vision	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Marked	<input type="checkbox"/> Severe
Ghost Images	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Marked	<input type="checkbox"/> Severe
Fluctuations of Vision	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Marked	<input type="checkbox"/> Severe
Difficulty with Night Driving	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Marked	<input type="checkbox"/> Severe
Variable Vision under:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Marked	<input type="checkbox"/> Severe
Bright Light/Sun	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Marked	<input type="checkbox"/> Severe
Normal/Indoor Light	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Marked	<input type="checkbox"/> Severe
Dim Light/After Dark	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Marked	<input type="checkbox"/> Severe

For Office Use Only:	<input type="checkbox"/> Pre-op	<input type="checkbox"/> Post-op _____	Reviewed by: _____
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