THE LA JOLLA INSTITUTE
OF PLASTIC SURGERY
James Casimir Pietraszek, M.D., F.A.C.S.

EYE SURGERY QUESTIONNAIRE

Please complete this form in order to assist Dr. Pietraszek in discussing your surgical needs and goals.

NAME:____________________________________ **DATE:**

1. HAVE YOU EVER HAD EYE SURGERY? YES ( ) NO ( )

IF **YES**, WHEN?____

NAME OF SURGEON?____

2. HAVE YOU EVER INJURED YOUR EYES? YES ( ) NO ( )

IF SO, WHEN?___________ IF **YES**, HOW? _______________________________________

____

WHO TREATED YOU? ____

3. WHAT DO YOU FEEL IS THE CHIEF PROBLEM WITH YOUR EYES NOW?

____

4. DO YOU WEAR GLASSES OR CONTACT LENSES? YES ( ) NO ( )

5. DO YOU HAVE ANY PROBLEMS WITH YOUR VISION? YES ( ) NO ( )

IF **YES**, PLEASE DESCRIBE THE PROBLEM. ______________________________________

____

6. DO YOU HAVE ALLERGIES AND HAY FEVER? YES ( ) NO ( )

7. DO YOU EVER EXPERIENCE EXCESSIVE DRYNESS, SCRATCHINESS, OR TEARING IN YOUR EYES? YES ( ) NO ( )

IF **YES**, UNDER WHAT CIRCUMSTANCES: ____

____

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