

OCULAR INFORMATION



CO-MANAGING DOCTOR:

Doctor's Name: _____
 Contact Person: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Office Phone: _____
 Email: _____
 Cell Phone: _____

PATIENT INFORMATION:

Name (Last): _____ First: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone (Home): _____ Phone (Cell): _____
 Email: _____
 Date of Birth: ____/____/____ Age: ____ Male Female
Month Date Year
 Patient scheduled for the following: Surgery
 Consult/Testing Enhancement Date: _____

REFRACTIVE INFORMATION:

Wear: OD: _____ 20/ OS: _____ 20/ Date: _____
 DRY: OD: _____ 20/ OS: _____ 20/ Date: _____
 CYCLO: OD: _____ 20/ OS: _____ 20/ Date: _____
 ADD: + _____ D K's OD: _____ / _____ @ _____ OS: _____ / _____ @ _____

DOMINANT EYE: OD OS RX Stable X 12 Months (<0.50 D Change)? Y N

Contact Lens Use:

D.W. SCL X.W. SCL Toric SCL RGP PMMA Contacts Removed on (Date): _____

Dilation: Y N Pupils (Dim Illumination) in mm: OD: _____ OS: _____ Binocular Testing: Normal / Other

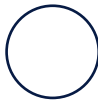
OD:

ANTERIOR AND POSTERIOR EXAMINATION

OS:

Anterior Chamber:

Lids/Lashes: Clear / Blepharitis
 Conj: White / Injected
 Cornea: Clear
 Neo: _____ / 4 +



Anterior Chamber:

Quiet & Deep / Shallow
 Lenticular Opacities:

IOP: _____ mm @

Anterior Segment:

Lids/Lashes: Clear / Blepharitis
 Conj: White / Injected
 Cornea: Clear
 Neo: _____ / 4 +



Anterior Chamber:

Quiet & Deep / Shallow
 Lenticular Opacities:

IOP: _____ mm @

Comments or other Medical / Ocular History:

VA sc OD 20/
 OS 20/

Autorefracton OD
 OS

Central Pachymetry

OD | _____ | _____ | _____ |

OS | _____ | _____ | _____ |

Schirmer 5min OD | _____ |

OS | _____ |

Recommend:

OU OD ONLY
 LASIK PRK OS ONLY
 Aim Distance OU Aim Near OD / OS LRI
 Mono Target: _____ Diopters

Discussed with patients:

Risks/ Benefits Reading Post Op Enhancement

1 Day Post Operative Care to be Completed by:

Surgeon Comanaging Doctor

Fees Quoted: _____ Payment Plan: Y N

Dr. Signature: _____ Print: _____ Date: _____