

Laser Vision Correction Evaluation

First Name _____ M.I. _____ Last Name _____ Occupation _____ Acct # _____
 Age _____ Date of Birth ____/____/____ Sex _____ Referring OD _____ Date ____/____/____

History CC/HPI: _____

ROS/PFSH REVIEWED: NO CHANGE SINCE _____

REVIEW OF SYSTEMS (ROS): Reviewed By _____

Y N

- CONSTITUTIONAL _____
- EYES _____
- EARS, NOSE, MOUTH, THROAT _____
- CARDIOVASCULAR _____
- RESPIRATORY _____
- GASTROINTESTINAL _____
- GENITOURINARY _____
- INTEGUMENTARY _____
- MUSCULOSKELETAL _____
- NEUROLOGICAL _____
- HEMATOLOGIC/LYMPHATIC _____
- ALLERGIC/IMMUNOLOGIC _____
- ENDOCRINE _____
- OTHER _____

SOCIAL HISTORY:

Y N

- DRUGS _____
- ALCOHOL _____
- TOBACCO _____

FAMILY HISTORY:

Nonpertinent Pertinent _____

CORRECTIVE LENSES:

HCTL GPCTL Last Worn: _____
 SCTL GLASSES Years Worn: _____

CONTRAINDICATIONS (RELATIVE):

Y N

- Dry Eyes
- Glaucoma
- Rx Change in 12 mo
- Diabetes Mellitus
- Inflammatory Corneal Disease

ALLERGIES:

MEDICATIONS:

PAST MEDICAL HISTORY:

PAST OCULAR HISTORY / OPHTHALMIC MEDICATIONS:

GOAL:

CONTRAINDICATIONS (ABSOLUTE):

Y N

- External Disease
- Keratoconus
- Active Ocular Infection
- Recurrent Corneal Erosion

Y N

- Hx of Herpes Simplex
- Irregular Astigmatism
- Connective Tissue Disease
- Corneal Abrasion

Name _____

Date of SCREENING: _____

Current Rx

O.D. _____ SPH _____ CYL _____ Axis _____
 O.S. _____ SPH _____ CYL _____ Axis _____

VAsc O.D. 20/ _____ **Near** O.D. 20/ _____
 O.S. 20/ _____ O.S. 20/ _____

VAcc O.D. 20/ _____ **Near** O.D. 20/ _____
 O.S. 20/ _____ O.S. 20/ _____

Keratometry

O.D. K1 _____ K2 _____ K2Axis _____

O.S. K1 _____ K2 _____ K2Axis _____

Manifest Refraction

O.D. _____ SPH _____ CYL _____ Axis 20/ _____
 O.S. _____ SPH _____ CYL _____ Axis 20/ _____

Add Power _____

Pupils (mm)

O.D. light _____ O.D. dark _____
 O.S. light _____ O.S. dark _____

Pachymetry

O.D. _____ O.S. _____

- Reviewed Level of Correction
- Reviewed Pupil Size
- Reviewed Corneal Shape & Thickness

Diagnosis/Plan

BHREI to call _____
 CK CRYSTALENS CUSTOM LASIK LASIK
 IOL: PHAKIC / ACCOMMODATING

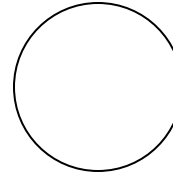
Signature

Dominant Eye _____

Date of PRE-OP: _____

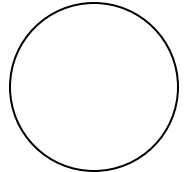
WNL O.D.

- lids/lashes
- conj
- cornea
- iris
- a/c
- lens



WNL O.S.

- lids/lashes
- conj
- cornea
- iris
- a/c
- lens



IOP

O.D. _____ mmHg O.S. _____ mmHg

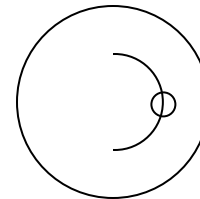
Cyclo 1% @ _____

Cycloplegic Refraction

O.D. _____ SPH _____ CYL _____ Axis 20/ _____
 O.S. _____ SPH _____ CYL _____ Axis 20/ _____

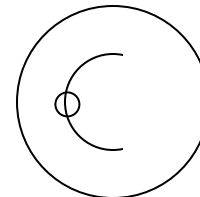
Fundus WNL O.D.

- macula
 - periph
- _____ c:d



Fundus WNL O.S.

- macula
 - periph
- _____ c:d



Diagnosis/Plan

- Reviewed Informed Consent DVD _____
- Reviewed Instructions _____
- Discussed expectations, risk/benefit, enhancement _____

Signature