

Today's Date: _____ Patient's Date of Birth: ____ / ____ / ____

Patient's Last Name: _____ Patient's First Name: _____ Age: ____

Patient's Phone: _____ Patient's Email: _____

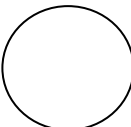
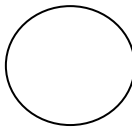
Ocular History: _____

Contact Lens History: _____ Date CL Discontinued: _____

Medical History: _____

Medications: _____ Allergies: _____

<p>UNCORRECTED VA:</p> <table border="0"> <tr> <td></td> <td style="text-align: center;"><u>DV</u></td> <td></td> <td style="text-align: center;"><u>NV</u></td> </tr> <tr> <td>OD 20/____</td> <td></td> <td>OD J ____</td> <td></td> </tr> <tr> <td>OS 20/____</td> <td></td> <td>OS J ____</td> <td></td> </tr> </table>		<u>DV</u>		<u>NV</u>	OD 20/____		OD J ____		OS 20/____		OS J ____		<p>Pupils: _____ OD _____ mm OS _____ mm</p> <p>Dominant Eye: <input type="checkbox"/> OD <input type="checkbox"/> OS Muscle Balance: <input type="checkbox"/> Normal <input type="checkbox"/> Other: _____</p> <p>IOP: OD _____ OS _____ Time: _____ Pachymetry: OD _____ OS _____</p>
	<u>DV</u>		<u>NV</u>										
OD 20/____		OD J ____											
OS 20/____		OS J ____											
Rx Spectacle Correction:	OD _____ x _____ ° 20/____	OS _____ x _____ ° 20/____											
Manifest Refraction:	OD _____ x _____ ° 20/____	OS _____ x _____ ° 20/____											
Dilated Refraction:	OD _____ x _____ ° 20/____	OS _____ x _____ ° 20/____											
Keratometry:	OD flat _____ @ _____ ° steep _____	OS flat _____ @ _____ ° steep _____											

<p>Slit Lamp Exam: OD TBUT _____</p> <p>Lids _____</p> <p>Conj _____</p> <p>AC _____</p> <p>Lens _____</p> <p>Disc _____</p> <p>Macula _____</p> <p>Periphery _____</p>	<p>OS TBUT _____</p> <p>Lids _____</p> <p>Conj _____</p> <p>AC _____</p> <p>Lens _____</p> <p>Disc _____</p> <p>Macula _____</p> <p>Periphery _____</p>
<p>Cornea </p>	<p>Cornea </p>

Monovision Discussed: Yes No **Monovision Trialed:** Yes No

If YES: Near Eye OD OS Residual Myopia Target - _____ D for near eye

LASIK: OD OS OU **ENHANCE:** OD OS OU

PRK: OD OS OU **TARGET DISTANCE OU:** Yes No

IVG-LASIK to call patient to schedule consultation and/or surgery? Yes No

Comments: _____

DOCTOR'S SIGNATURE: _____

Pease Print Doctor's Name: _____ **Doctor's Phone:** _____