PRE-OPERATIVE REFRACTIVE SURGERY FORM

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: __________________________

UNCORRECTED VA:

	DV		**NV**
OD 20/______		**OD J**______	
OS 20/______		**OS J**______	

Pupils: __________ OD _____ mm OS _____ mm

Dominant Eye: ☐ OD ☐ OS Muscle Balance: ☐ Normal ☐ Other:__________

IOP: OD_______ OS_______ Time:________ Pachymetry: OD_______ OS_______

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 _______ @ _______° **OS** flat _______ @ _______
steep _______ steep _______

Slit Lamp Exam: **OD** **TBUT** ________

Lids ____________
Conj ____________
AC ____________
Lens ____________
Disc ____________
Macula __________
Periphery _______

Cornea

OS **TBUT** ________

Lids ____________
Conj ____________
AC ____________
Lens ____________
Disc ____________
Macula __________
Periphery _______

Cornea

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: ____

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DOCTOR'S SIGNATURE: ____

Pease Print Doctor's Name: _______________________________________ **Doctor's Phone:** __________________

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