PRE-OP / POST-OP LASIK EVALUATION

PATIENT NAME: ______________________ DOB: ________ DATE: ________

Ocular Surgeries/Hx/Complaints: ______________________ Occupation: ________

______________________ Ocular Meds: ________

______________________ Dominant Eye: OD / OS

Present RX __________Yrs. CL History: __________Yrs. IOP's OD ________

OD Hard / Soft DW / EW OS ________

OS Last Worn: ________

VA sc OD________ VA cc OD________ NA cc OD________ Pupils OD ________

OS ________ OS ________ OS________ OS ________

K's OD_____/_____ @ ______ Auto/Manual Dilation: Myd 0.5% Neo 2.5%

OS_____/_____ @ ______ Myd 1% Cyclo 1%

MANIFEST REF		CYCLO REF	
OD	20/	OD	20/
OS	20/	OS	20/

RIGHT EYE		LEFT EYE	
Cornea	________	Cornea	________
Endoth	________	Endoth	________
AC	________	AC	________
Lens	________	Lens	________
Disc	________	Disc	________
Macula	________	Macula	________
Retina	________	Retina	________

D/C CL's ____________ (date) EXAMINER'S NAME ____________

Co-managment was discussed with this patient and at his/her request: EXAMINER'S SIGNATURE: ____________

I ____ will ____ will not co-manage this patient. PATIENT'S SIGNATURE: ____________

EXAM DATE: ____________ TARGET: OD ____________

SURGERY DATE/S: ____________ OS ____________

SURGICAL PLAN: ______________________

Dr. Signature ______________________TF /

POST-OP EXAM: ____________

VA sc: OD: ____________ SLIT LAMP:

OS: ____________

REFRACTION:

OD: ____________ = 20/____

OS: ____________ = 20/____

OD	OS
Retina:	Retina:

Post-op Meds: ____________

Recommedations/Comments: ______________________

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Dr. Signature: ______________________ TF /