



# Pre-Operative Evaluation

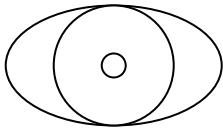
Patient Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ City: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age Seen: \_\_\_\_\_ Pre-op Date: [ ] Surgery Date: \_\_\_\_\_

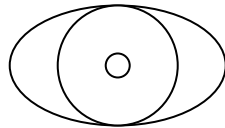
Glasses Last RX _____ years old Last Exam _____ years old Bifocal / Progressive	Contact Lenses Used for _____ months/years Type: _____	History: _____ Halos / Glare pre-op (Specs/CLs) <b>General Health:</b>  <b>Ocular History:</b>
Medications _____ Allergies: _____		

V	OD	UCVA: 20/		
	Sph	Cyl	Ax	BSCVA
Specs Rx:	_____ 20/ _____			
Auto:	_____ 20/ _____			
Manifest:	[ ]	[ ]	[ ]	20/ [ ]
Cycloplegic:	[ ]	[ ]	[ ]	[ ]
Cornel Thickness :	Orbscan	Low	Central	
	[ ]	[ ]	[ ]	
	Ultrasound: _____			
K Readings:	Max K	Max Ax	Min K	Min Ax
	_____ x _____	/	_____ x _____	

OS	UCVA: 20/		
[ ]	[ ]	[ ]	[ ]
[ ]	[ ]	[ ]	[ ]
[ ]	[ ]	[ ]	[ ]
[ ]	[ ]	[ ]	[ ]
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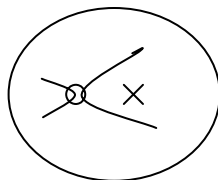
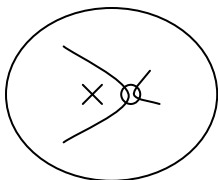


OD



OS

- |               |                          |                          |                          |              |
|---------------|--------------------------|--------------------------|--------------------------|--------------|
| Normal:       | <input type="checkbox"/> | _____ Lids/ Lashes _____ | <input type="checkbox"/> | Normal.      |
| Clear         | <input type="checkbox"/> | _____ Conjunctiva _____  | <input type="checkbox"/> | Clear.       |
| Clear         | <input type="checkbox"/> | _____ Cornea _____       | <input type="checkbox"/> | Clear.       |
| Deep / Quiet: | <input type="checkbox"/> | _____ Ant Cham _____     | <input type="checkbox"/> | Deep / Quiet |
| Normal:       | <input type="checkbox"/> | _____ Iris _____         | <input type="checkbox"/> | Normal.      |
| Clear :       | <input type="checkbox"/> | _____ Lens _____         | <input type="checkbox"/> | Clear.       |
| ____/ ____:   | <input type="checkbox"/> | _____ Disc _____         | <input type="checkbox"/> | ____/ ____   |
| Normal:       | <input type="checkbox"/> | _____ Macula _____       | <input type="checkbox"/> | Normal.      |
| Normal:       | <input type="checkbox"/> | _____ Periphery _____    | <input type="checkbox"/> | Normal.      |
- P/V/M/D



Tears:  Normal  Deris  Dry

Breakup Time: Normal / \_\_\_\_\_

Dilation Time: \_\_\_\_\_ Tropicamide \_\_\_\_\_ % Phenyleph % \_\_\_\_\_

<b>Discussed:</b> <input type="checkbox"/> Lasik <input type="checkbox"/> PRK <input type="checkbox"/> Single Treat <input type="checkbox"/> Undercorrect	<input type="checkbox"/> Presbyopia <input type="checkbox"/> Monovision <input type="checkbox"/> CL's our pre -Sx	<b>Explained Risk of</b> <input type="checkbox"/> Loss of BSCVA : <input type="checkbox"/> Haloes / Glare <input type="checkbox"/> Haze <input type="checkbox"/> Night Vision Disturb	<input type="checkbox"/> Bleed / Infamm <input type="checkbox"/> DLK <input type="checkbox"/> Epi Defect <input type="checkbox"/> Regression
<b>Discussed:</b> <input type="checkbox"/> Lasik <input type="checkbox"/> PRK <input type="checkbox"/> Patient Undecided	<b>Explained Risk of</b> <input type="checkbox"/> OD <input type="checkbox"/> OS <input type="checkbox"/> OU <input type="checkbox"/> Full Correction <input type="checkbox"/> Monovision <input type="checkbox"/> Consult with Surgeon		

Unsuitable  
Due to: \_\_\_\_\_

NOTES	RMS	OD

Height	Weight	BP	Pulse	Temp
/				

Examined By: \_\_\_\_\_