Eye Doctors OF WASHINGTON

REFRACTIVE SURGERY – INITIAL EVALUATION

Name:_____ Date: _____

DOB:_____AGE:_____y/o

Occupation_____

Co-Mngmt Dr._____

MEDICAL HISTORY:

Diabetes	Y	N
Immmunodeficiency	Y	N
Collagen Vascular	Y	N
Pregnancy	Y	N
Cosmetic Surgery	Y	N
Keloid	Y	N

Other:

OCULAR HISTORY:

Dry Eyes	Y	N
Sjogren's Syndrome	Y	N
Recurrent Erosions	Y	N
Herpes Simplex	Y	N
Previous Refractive Surgery	Y	N

Other:

REASONS FOR SURGERY:

[ ] less dependence–glasses/contacts
[ ] occupational requirement
[ ] contact lens intolerance
[ ] recreational activities
[ ] other:

CONTACT LENSES: Y N
Type (circle): HCL GPHCL SCL
Hrs/day: Days/wk:
Years worn: Last worn:
How long has glasses/contact lens prescription been stable?

MEDICATIONS:

- ❑ Accutane
- ❑ Imitrex
- ❑ Amiodorone

FAMILY HISTORY:

Keratoconus Y N
Cornea Transplant Y N
Other:

ALLERGIES:

□ NKDA

Surgeon:

	OD	OS
UCVA:	20/	20/
BSCVA:	20/	20/
NEAR (UCVA):	20/	20/
PUPIL (Room):	_____ mm	_____ mm
PUPIL (Dim):	_____ mm	_____ mm

Dominance OD OS
Mono contacts in past:

IOP	MOTILITY	DILATION
OD: _____	[ ] WNL	N&M C½% C1%
OS: _____		TIME:

	OD	OS
Lids/Lashes	[ ] WNL	[ ] WNL
Conjunctiva	[ ] WNL	[ ] WNL
Cornea	[ ] WNL	[ ] WNL
AC	[ ] WNL	[ ] WNL
Iris	[ ] WNL	[ ] WNL
Lens	[ ] WNL	[ ] WNL
Tear Film	[ ] WNL	[ ] WNL
Tear BUT	[ ] WNL	[ ] WNL
Optic Disc	[ ] WNL	[ ] WNL
Macula	[ ] WNL	[ ] WNL
Periphery	[ ] WNL	[ ] WNL
Pachymetry		

EYE: OD OS
PROCEDURE: Lasik • PRK • Lasik • PRK •
LASER: Cust • STD Cust • STD
CORRECTION: Dist • Near Dist • Near
TARGET RX: _____ _____

Price OD _____ OS _____

RX
OD __ __ __. __ __ __ __. __ __ __ __ __ __°
OS __ __ __. __ __ __ __. __ __ __ __ __ __°

MR
OD __ __ __. __ __ __ __. __ __ __ __ __ __° 20/_____
OS __ __ __. __ __ __ __. __ __ __ __ __ __° 20/_____

CR
OD __ __ __. __ __ __ __. __ __ __ __ __ __° 20/_____
OS __ __ __. __ __ __ __. __ __ __ __ __ __° 20/_____

Ks

	FLAT	STEEP	FLAT AXIS
OD	___ ___.___	___ ___.___	___ ___ ___°
OS	___ ___.___	___ ___.___	___ ___ ___°

Calculation –Treatment (Surgeon)

OD __ __ __. __ __ __ __ __. __ __ X __ __ __°
TX Sph *TX Cyl* *TX Axis*

OS __ __ __. __ __ __ __ __. __ __ X __ __ __°
TX Sph *TX Cyl* *TX Axis*

Nomogram adjustment –Treatment

OD __ __ __. __ __ __ __ __. __ __ X __ __ __°
TX Sph *TX Cyl* *TX Axis*

OS __ __ __. __ __ __ __ __. __ __ X __ __ __°
TX Sph *TX Cyl* *TX A*

Femto settings: _____/_____ OD _____/_____ OS

Pachymetry (Bed) _____ OD _____ OS

MMC: OD OS **TOPO REVIEW** [ ]

Surgical Note:

Verification Steps

1. _____ Tech
2. _____ Doc
3. _____ Tech
4. _____ Doc
5. _____ Tech

Please fax to (240) 235-4249 attn: Refractive Coordinator

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