Eye Doctors OF WASHINGTON

Co-Mngmt Dr._____

# REFRACTIVE SURGERY – INITIAL EVALUATION

Name:_____ Date: _____

DOB:_____AGE:_____y/o

Occupation_____

**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
[ ] contact lens intolerance
[ ] other:
[ ] occupational requirement
[ ] recreational activities

**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 ❑ LATEX ❑ IODINE

**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 |
| Conjunctiva | | | [ ] WNL |
| Cornea | | | [ ] WNL |
| AC | | | [ ] WNL |
| Iris | | | [ ] WNL |
| Lens | | | [ ] WNL |
| Tear Film | | | [ ] WNL |
| Tear BUT | | | [ ] WNL |
| Optic Disc | | | [ ] WNL |
| Macula | | | [ ] WNL |
| Periphery | | | [ ] 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 (202) 688-2977 attn: Refractive Coordinator**

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