EYE-Q

LASIK Preop Exam

Patient Information

Name ______________________________
Age ________________

Address ______________________________

City ______________________ State ______
Zip ________________

H Phone____________ W Phone ____________

Referring Doctor Information

Name ______________________________

Address ______________________________

City ______________________ State ______
Zip ________________

Date of Examination: ______/______/______

History

Ocular History:

Family Ocular History:

Medical History:

Medications:

Allergies:

Wet or Dry Eyes	Yes	No
Glare	Yes	No
Rx Stable for One Year	Yes	No
Pregnant or Nursing	Yes	No
Cl Out for Appropriate Time	Yes	No

Dilation Requires Mydriacyl 1% Refract 30 minutes later	**OD**		**OS**	
Visual Acuity	cc 20/	sc 20/	cc 20/	sc 20/
IOP	mmHg		mmHg	
Schirmers	mm		mm	
Manifest Refraction	20/		20/	
Distance Rx Stable for at least (1) year	Yes	No	Yes	No
Cycloplegic Refraction **(No Cyclogyl)** Only Mydriacyl 1%	20/		20/	
Pupil Size (light/dark)	mm/	mm	mm/	mm
Conjunctiva				
Cornea				
AC				
Lens				
Disc				
Retinal Vessels				
Macula				
Peripheral Retina			**Date of Surgery:** _____/_____/_____	
Keratometry Readings				
If Monovision: Desired Endpoint	Yes	No		
	Please fax form to **(559) 256-8484** Attn: **LASIK** Prior to the Monday before Surgery			

V159 (10/28/08)