



Pre-Procedure Patient Examination

3900 Essex Lane Suite 101, Houston, TX 77027 Phone 713-626-5544 Fax 713-626-7744

COMANAGING DOCTOR

Doctor Name _____ Contact Person _____
 Phone # _____ Address _____
 Fax # _____ Email _____

PATIENT

Last Name _____ First Name _____
 Address _____
 Home Phone _____ WorkPhone _____
 Sx Date _____ Time _____ Fee Quoted _____

PRE-PROCEDURE EVALUATION

UCVA OD 20/ _____ UCVA OS 20/ _____
 Current RX OD _____ 20/ _____ OS _____ 20/ _____
 Cyclo (Date) OD _____ 20/ _____ OS _____ 20/ _____
 Dry (Date) OD _____ 20/ _____ OS _____ 20/ _____
 Pupil Size _____ Dominant Eye OD OS
 Contact Lens Use DW SCL EWSCL Toric SCL RGP PMMA
 Contacts Removed (Date) _____ K's OD _____ / _____ OS _____ / _____
 Ocular Medical History _____ Ocular Surgical History _____

OCULAR EXAMINATION

Anterior Segment	Lids/Conj	Cornea	Lens	IOP
	OD clear/blepharitis	clear/opacities/neovasc/dystrophy	clear/opacities	_____ mmHg
	OS clear/blepharitis	clear/opacities/neovasc/dystrophy	clear/opacities	_____ mmHg
Posterior Segment	C/D	Myopic Degeneration	Peripheral Retina	Schirmers
Dilated	OD 0.	None 1 2 3 4 severe	normal / lattice / pavingstone / RD / holes	OD _____
	OS 0.	None 1 2 3 4 severe	normal / lattice / pavingstone / RD / holes	OS _____
Recommended Surgery:	<input type="checkbox"/> PRK	<input type="checkbox"/> LASIK	<input type="checkbox"/> PTK	<input type="checkbox"/> Bilateral
	<input type="checkbox"/> OD first	<input type="checkbox"/> OS first	<input type="checkbox"/> Aim Distance OU	
	<input type="checkbox"/> Aim Near OD	<input type="checkbox"/> Aim Near OS	<input type="checkbox"/> Mono Target _____	
Discussed:	<input type="checkbox"/> Benefits & Risks <input type="checkbox"/> Presbyopia/Mono		<input type="checkbox"/> Enhancements	
Comments _____				

Dr. Signature _____ Date _____