

Pre-Operative Evaluation Form

Co-managing Doctor: _____ **Phone #:** _____

Patient Name: _____ **Date:** _____

Current Prescription:

OD _____ How Long? _____

OS _____ How Long? _____

| | <u>UCVA</u> | <u>J</u> | <u>BCVA</u> | <u>REFRACTION</u> | <u>CYCLOPLEGIC</u> |
|----|-------------|----------|-------------|-----------------------|-----------------------|
| OD | 20/___ | ___ | 20/___ | _____ - _____ X _____ | _____ - _____ X _____ |
| OS | 20/___ | ___ | 20/___ | _____ - _____ X _____ | _____ - _____ X _____ |

Pupils: Photopic ___mm Scotopic: ___mm **Vertex Distance:** _____ **Dominant Eye:** _____

Monovision: Yes No (If Yes, please complete below)

Current Contact Lens RX

Add

OD _____

OS _____

Pachymetry: OD _____ OS _____

Desired Correction:

OD _____ RING SIZE _____

OS _____ RING SIZE _____

| | | | | | | |
|--------------------------|-----------------|-------|------------|--|------------------------|----------------|
| | FLAT | STEEP | STEEP AXIS | | IOP | OD_____OS_____ |
| <u>K Readings</u> | OD_____ / _____ | _____ | X_____ | | <u>Schirmer</u> | OD_____OS_____ |
| | OS_____ / _____ | _____ | X_____ | | | |

(With Alcaine)

Slit Lamp Exam: (significant findings)

Fundus Exam: (significant findings)

OD OS

OD OS

Consent Forms Given? _____ **Payment Discussed?** _____ **Contacts Out Prior to Surgery?** _____

Surgery Date: _____ @ _____ POV1: _____ @ _____