

Questions? 877-508-2020

**PRE-OPERATIVE EXAMINATION**

Renton /  Spokane /  Boise /  Central Oregon /  S. Portland

ID#: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Pre-op Date: \_\_\_\_\_ Surgery Date: \_\_\_\_\_

CC: \_\_\_\_\_ EYE MEDS: \_\_\_\_\_

Change in Medical/Social HX + / - \_\_\_\_\_

HISTORY	+	-
FhX		
Prev Eye HX		
Eye Surgery		
Systemic Meds		
Allergies		

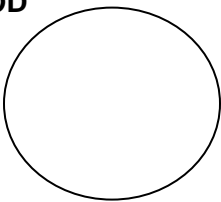
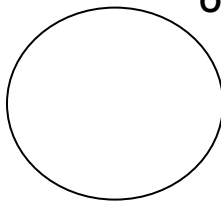
HISTORY	+	-
Diabetes		
HTN		
Cardio-Vasc		
Respiratory		
Other		

HISTORY			
Glasses	Bifocal	Trifocal	Prism
CL Type:	None	Soft/Toric	RGP/Hard
CL Frequency of Use:	Prolong	Daily	Rarely
CL Date last worn:		CL Years worn total:	

V	OD UCVA: 20/				OS UCVA: 20/					
Specs Rx:	Sph	Cyl	Ax	BSCVA	Sph	Cyl	Ax	BSCVA		
How old:	_____ 20/ _____				_____ 20/ _____					
Wavescan:	_____ 20/ _____				_____ 20/ _____					
Manifest:	_____	_____	_____	20/ _____	_____	_____	_____	20/ _____		
Cyclo-Plegic	_____	_____	_____	20/ _____	_____	_____	_____	20/ _____		
Corneal Thickness:	Orbiscan:		Low _____	Central _____	Orbiscan:		Low _____	Central _____		
	Ultrasound:		_____	_____	Ultrasound:		_____	_____		
K Readings:	Max K _____	Max Ax _____	Min K _____	Min Ax _____	W2W _____	Max K _____	Max Ax _____	Min K _____	Min Ax _____	W2W _____

Pupils	APD	No APD
Phot	OD _____	OS _____
Scot:	_____	_____
Dominance: <input type="checkbox"/> OD <input type="checkbox"/> OS		
IOP: OD _____ OS _____		
Time: _____		
Tears: <input type="checkbox"/> Normal <input type="checkbox"/> Debris <input type="checkbox"/> Dry		
Breakup Time: _____		
Dilation Time: _____		
<input type="checkbox"/> Cyclogel: 1% <input type="checkbox"/> Tropicamide: 1% <input type="checkbox"/> Phenyloph: 2.5%		

	OD		OS	
	+	-	+	-
External Exam				
Lida Adnexa				
Pupils 2 3 4 5 6 7				
EOM				
Conf. Fields				
Other test/exam				
Slit Lamp				
Conjunctiva				
Cornea				
Ant. Chamber				
Iris				
Lens				
Ant. Vit.				
Fundus/Dir/Bio Lens 20/90				
C/D OD 1 2 3 4 5 6 7 8 9				
C/D OS 1 2 3 4 5 6 7 8 9				
Vessels				
Macula				
Periphery				

**OD**  **OS** 

Assessment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- LASIK/PRK Discussion:**
- Night VA
  - Glare
  - Halo Effect
  - Star Burst
  - Dryness
  - Fluctuating VA's
  - Presbyopia
  - Mono Vision Y / N
  - Healing Rate
  - Eye Protection
  - Regression
  - Enhancement
  - Infection
  - Flap Dislocation
  - Contrast Sensitivity
  - Discuss pts questions / concerns

- Plan:**
- WAVEFRONT
  - INTRALASE
  - LASIK
  - PRK
    - Full Correction
    - Monovision
    - OD
    - OS
    - OU
  - Consult with Surgeon
  - Patient Undecided

- Referred from RVC
- Referred by O.D.

Examined by (co-managing doctor please provide Name, Address, Phone, and Fax numbers): \_\_\_\_\_

Doctor's initials: \_\_\_\_\_