BRAVERMAN EYE CENTER
PATIENT REVIEW FORM

PATIENT NAME: ________________________________ **Date**__________
PATIENT PHONE #: ____________________**Age:** ___ **Occupation:** ________
ECP: _______________**ECP Phone:**____________________ **Email:**________

MEDICAL HX:

Family Hx: ______________________________
Active Conditions: _______________________
Meds: _________________________________
Allergies: ______________________________
Misc Med: ______________________________

OCULAR HX:

Contact Lens DWSL EWSL STL RGP PMMA
CL last worn: ________**yrs. of cl wear**_______

Misc Eye: ____

REFRACTIVE EXAM: (Date__________/Examiner________________)

Spec Rx OD____________________**20/** **OS**______________________________**20/**

Dry Rx OD____________________**20/** **OS**______________________________**20/**

K Readings OD______________________ **OS**______________________________

OCULAR EXAM: (date:___________/ examiner: ______________________)

	OD		OS	
Lids	NL	Blepharitis	NL	Blepharitis
TA	__________		__________	
Schirmer (>40 yo)	________(w/ anesth.)		________(w/ anesth.)	
TBUT	______________________		______________________	
Conj	NL	Other:__________________	NL	Other:__________________
K Epith	NL	Other:__________________	NL	Other:__________________
K Stroma	NL	Other:__________________	NL	Other:__________________
K Misc	Vogt's Striae Y N____________		Fleischer's Ring Y N________________	
Keratometry	OD__________________________		OS__________________________	
AC/Iris	NL	Other:__________________	NL	Other:__________________
Lens:	NL	Other:__________________	NL	Other:__________________
Fundus	NL	Other:__________C/D____	NL	Other:____________C/D____
Misc	______________________		______________________	
Topo	NL	Other(attached)__________	NL	Other(attached)____________
PACHYMETRY	OD_______	OS_______		

IMP: Keratoconus / Post Lasik Ectasia
EYE(S): OD OS OU

Fax to Attention: Rosemary at 954-458-7186

10-26-2016