

BRAVERMAN EYE CENTER LASER VISION
PREOPERATIVE PATIENT REVIEW FORM

PATIENT NAME: _____ Date _____
 PATIENT PHONE #: _____ Age: ____ Occupation: _____
 ECP: _____ ECP Phone: _____ Email: _____

<u>MEDICAL HX:</u>	<u>OCULAR HX:</u>
Family Hx: _____	Contact Lens DWSL EWSL STL RGP PMMA
Active Conditions: _____	CL last worn: _____ yrs. of cl wear _____
Meds: _____	Active Eye Conditions: _____
Allergies: _____	Dry Eyes: Y N (if Y, describe below)
Misc Med: _____	Glare: Y N (if Y, describe below)
Misc Eye: _____	

REFRACTIVE EXAM: (Date _____ / Examiner _____)	
Spec Rx OD _____ 20/	OS _____ 20/
Dry Rx OD _____ 20/	OS _____ 20/
Cyclogyl Rx OD _____ 20/	OS _____ 20/
K Readings OD _____	OS _____
STABILITY(12 mo.) Y N	Y N
Evidence: _____	Dominant Eye _____

<u>OCULAR EXAM:</u> (date: _____ / examiner: _____)	
<u>OD</u>	<u>OS</u>
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) _____
Pupils (Scotopic) OD _____ OS _____	PACHYMETRY OD _____ OS _____

IMP: MYOPIA / HYPEROPIA / PRESBYOPIA / ASTIGMATISM / ENHANCEMENT

PLAN: LASIK / PRESBYLASIK / PRK --EYE(S): OD__ OS__ OU__

MONOVISION: N Y (Reading Eye = O__ ; target: _____)