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INITIAL REFRACTIVE SURGERY ASSESSMENT Date: \_\_\_/\_\_\_/20\_\_\_

Referring Dr. \_\_\_\_\_ Surgeon \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_

Address \_\_\_\_\_ WK Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_

City / State / Zip \_\_\_\_\_ HM Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_

Comanagement discussed and requested by the patient (circle): Y N Patient Desires: [ ] LASIK [ ] PRK
[ ] INTRALASIK [ ] Epi-LASEK [ ] W/ Wavefront [ ] Intacs [ ] Phakic IOL [ ] Crystalens

Other: \_\_\_\_\_ Laser Center preferred (city): \_\_\_\_\_

Assessment
Ocular History: (e.g. injury, amblyopia, previous surgery, problems with lens wear, etc...) \_\_\_\_\_

Medical History: [ ] diabetes [ ] hypertension [ ] asthma [ ] collagen vascular disorder
[ ] other: \_\_\_\_\_

Medication: Ocular \_\_\_\_\_ Systemic \_\_\_\_\_

Allergies: \_\_\_\_\_ Present Correction: [ ] Glasses [ ] Contacts

Contact Lenses: [ ] Soft Daily Wear [ ] Soft Extended Wear [ ] RGP

Contacts Last Worn: (RGP at least 4 weeks, SCL at least 3 days): \_\_\_\_\_

VAsc OD 20/\_\_\_\_ OS 20/\_\_\_\_ Near VAcc OD \_\_\_\_ OS \_\_\_\_

Table with 4 columns: Manifest Refraction, Cycloplegic Refraction, Keratometry Readings, and VA. Rows for OD and OS.

Intraocular Pressure (circle: Apl. / NCT / Tonopen ) OD \_\_\_\_ OS \_\_\_\_ mm/Hg Pupil Size (dim) OD \_\_\_\_ OS \_\_\_\_

Ocular Motility / Pupil Exam Normal / Other \_\_\_\_\_ Normal / Other \_\_\_\_\_

Anterior Segment and Fundus Normal / Other \_\_\_\_\_ Normal / Other \_\_\_\_\_

Dominant Eye (circle): R L \_\_\_\_\_

Monovision Desired (circle): Y N Pachymetry: CCT OD: \_\_\_\_\_ OS \_\_\_\_\_

Comments: \_\_\_\_\_

One Day Post-op to be done by: [ ] Co-managing Doctor [ ] Surgeon
Please fax to (510) 357-6330 Assessing Doctor: \_\_\_\_\_