Personal Information

Name:	Date:	Chart #:

Race: ☐ White ☐ Black/African American ☐ Hispanic ☐ Asian ☐ American Indian/Alaskan ☐ Hawwaiian/Pacific Islander ☐ Declined

Smoking History ☐ Current Every Day Smoker ☐ Current Some Day Smoker ☐ Never Smoked

☐ Unknown ☐ Former Smoker : Date Started Smoking__________________ Date Quit__________________

Medical Insurance:

Pharmacy to Send Prescriptions to:	Name:
	Address:
	Phone:

Medical History

Any Herpetic Eye Disease	N	Y	Pregnant / Nursing	N	Y
Connective Tissue Disorder	N	Y	Keloid Former	N	Y
Diabetes	N	Y	Hypertension	N	Y
Pacemaker	N	Y	Cancer	N	Y

Previous Eye Surgery: N Y Kind of Surgery:____

Medications

Are you allergic to any medications?	N	Y	If yes, please list:
Are you taking medications for your eyes?	N	Y	If yes, please list:
Are you taking any other medications?	N	Y	If yes, please list:

Eye History

How many years ago was your last eye examination:

Do you wear glasses? N Y if yes, for: Distance Reading Both Glasses are __________ years old

Do you wear contacl lenses? N Y If yes: Hard or Soft Wearing for __________ years

What date were your contact lenses last in your eyes? Date:____________________ or ☐ **I am wearing them now.**

Do you ever note halos around lights or problems with glare using you current contact lenses or glasses? No or mild moderate servere

Primary Care Physician/Family Doctor

Name:

Address

Rev 9/18/08

CHART #

Patient Name:	Date of Birth:	Age:	Date:	Sex: M F
Home Address:				
City, State , Zip:	Home Phone:		Cell Phone:	
Employer Name and Address:	Work Phone:			
Occupation:	E-mail address:			
Name of person to call in case of emergency:	Phone:			
Reason for surgery:	Referred by:			

Discussed with patient:

- ☐ Glare & night vision problems
- ☐ Dry eye syndrome
- ☐ Flap complications / Intralase
- ☐ Loss of BCVA
- ☐ Lasik v. PRK
- ☐ Current Technology
- ☐ Enhancements
- ☐ Reading glasses / Monovision
- ☐ Video and print information
- ☐ ***Non-refundable*** deposit
- ☐ Discontinue contact lens wear for measurements

- ☐ Conventional
- ☐ Cust Myopia (up to -6.00)
- ☐ Cust High Myopia
- ☐ Cust Hyperopia
- ☐ Cust Mixed Astig
- ☐ iDesign

Emailed Yes

I understand the possible permanent risks of the procedure, including but not limited to the above. All of my questions were answered. I understand that 20/20 vision cannot be guaranteed. I have received the consent form.

Patient's Signature:________________ Date:__________ MD:__________

Contact Lens Hx: CL last in:__________

☐ PMH / POH Reviewed

☐ NKDA / Allergies:

Current Meds:

- ☐ Herpetic eye disease
- ☐ Connective tissue disease
- ☐ Diabetes
- ☐ Pacemaker
- ☐ Previous ocular surgery:
- ☐ Pregnant / Nursing

AR ______ ______ x ______
______ ______ x ______

V_{sc} ______ N ______
______ ______

W ______ ______ x ______ V ______
______ ______ x ______ ______

MR ______ ______ x ______ V ______
______ ______ x ______ ______

CR ______ ______ x ______ V ______
______ ______ x ______ ______

Dominant eye: OD OS

T_{ap} / iCare OD

OS

Central Pachymetry

Schirmer Testing

Strips QZ

Dilated with Tropicamide/Neo @________ OU OD OS

External/Motility/Pupil
☐ WNL / Other:

SLE
☐ WNL / Other:

Fundus
☐ WNL / Other: