TOWER CLOCK
EYE CENTER

PLEASE FAX PRE-OP FORM TO:
920 499-9636

PHONE: 920 499-3102

Pre-operative exam for LASIK/PRK procedures

Comanaging doctor:_____ Exam date:_____

Patient name:_____ DOB:_____ Age:_____

Procedure: LASIK PRK other

Medical history _____

Ocular history _____

Family history of ocular disease: Yes / No If yes, please explain _____

Current medications _____ Allergies _____

Occupational needs/hobbies _____

Present correction: Glasses: bifocal / trifocal / single vision CLs: SCL / RGP / HCL Date D/C'd CLs _____

DVAsc: OD_____ OS_____ NVAsc: OD_____ OS_____

Wearing: OD: Sphere_____ Cylinder_____ Axis_____ Add_____ 20/_____ Near VAcc: J_____

OS: Sphere_____ Cylinder_____ Axis_____ Add_____ 20/_____ Near VAcc: J_____

MR: OD: Sphere_____ Cylinder_____ Axis_____ 20/_____ Add_____

OS: Sphere_____ Cylinder_____ Axis_____ 20/_____ Add_____

CR: OD: Sphere_____ Cylinder_____ Axis_____ 20/_____

OS: Sphere_____ Cylinder_____ Axis_____ 20/_____

Ks OD_____@_____ Flat axis/_____@_____ Steep axis Average PACHS OD_____μ

Ks OS_____@_____ Flat axis/_____@_____ Steep axis OS_____μ

Dominant eye: OD OS Monovision: Yes No Planned MV target in diopters:_____

Topography done: Yes No (if yes, please send copy) IOP: OD_____ OS_____

Slit Lamp Exam: Normal / Abnormal If abnormal, please explain _____

☐ Patient informed and understands the need for readers after the age of 40 years of age

☐ Patient informed of risks / benefits / complications / and alternatives to their surgery

Additional notes:_____

_____

I have collected my comanagement fee: Yes No Amount collected: $_____

Signature_____