



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 _____