Lasik Vision Centers
of Cleveland

Pre-OP Evaluation

FAX To 216.674.6410

Patient : ______________________ Date of birth : ______________________ Age : ____________

Affiliate :______________________ Phone : ______________________ Fax : ______________________

OD	**OS**
UCVA _______	UCVA _______
Present Rx : ________________________ 20/_______	Present Rx : ________________________ 20/______
Dry Rx : ____________________________20/_______	Dry Rx : ____________________________20/______
Wet RX : ____________________________ 20/_______	Wet RX : ____________________________ 20/______
Pupil size _________ Contact Lens wear: yes / no	Pupil size _________ Contact Lens wear: yes/ no
Contact Lens type : D.W. SCL / X.W. SCL / RGP / Toric	Contact Lens type : D.W. SCL / X.W. SCL / RGP / Toric
Stable Rx for 6-12 months : yes / no	Stable Rx for 6-12 months : yes / no
Anterior Seg : Lids and Lashes : clear / bleph	***Anterior Seg*** : Lids and Lashes : clear / bleph
Cornea : clear / scarring / neo / dystrophy	Cornea : clear / scarring / neo / dystrophy
Lens : clear / opacities IOP_____	Lens : clear / opacities IOP_______
Posterior Seg: C/D 0.____	***Posterior Seg***: C/D 0.____
Retina Periph : normal / lattice / holes/ RD	Retina Periph : normal / lattice / holes/ RD
Discussed : Lasik / PRK / Mono / Risks / Enhancements	Discussed : Lasik / PRK / Mono / Risks / Enhancements
Comments : ______________________________	Comments : ______________________________
______________________________________	______________________________________

Affiliate : ______________________________ Date : ______________________________