



Pre-OP Evaluation

Patient : _____ Phone : _____ DOB : _____

Affiliate : _____ Phone : _____ Fax : _____

OD

UCVA _____

Present Rx : _____ 20/ _____

Dry Rx : _____ 20/ _____

Wet RX : _____ 20/ _____

Pupil size _____ Contact Lens wear: yes / no

Contact Lens type : D.W. SCL / X.W. SCL / RGP / Toric

Stable Rx for 6-12 months : yes / no

OS

UCVA _____

Present Rx : _____ 20/ _____

Dry Rx : _____ 20/ _____

Wet RX : _____ 20/ _____

Pupil size _____ Contact Lens wear: yes / no

Contact Lens type : D.W. SCL / X.W. SCL / RGP / Toric

Stable Rx for 6-12 months : yes / no

Anterior Seg : Lids and Lashes : clear / bleph

Cornea : clear / scarring / neo / dystrophy

Lens : clear / opacities IOP _____

Posterior Seg : C/D 0. _____

Retina Periph : normal / lattice / holes/ RD

Anterior Seg : Lids and Lashes : clear / bleph

Cornea : clear / scarring / neo / dystrophy

Lens : clear / opacities IOP _____

Posterior Seg : C/D 0. _____

Retina Periph : normal / lattice / holes/ RD

Discussed : Lasik / PRK / Mono / Risks / Enhancements

Comments : _____

Affiliate : _____

Discussed : Lasik / PRK / Mono / Risks / Enhancements

Comments : _____

Date : _____