Lasik Evaluation Form

Please fax to (717) 233-5715

Patient's information

Name _____
Last First MI
DOB _____

Surgeon _____

Co - Managing Doctor _____

Examination Date_____

Medical history
___ Pregnant/nursing ___Diabetes ___Sjogrens
___ Rheumatoid arthritis ___ Lupus ___ None
___ Pacemaker/ defibrillator

Ocular history
___ Cataracts ___ Glaucoma ___ None
___ Corneal disease ___ Dry eye
___ Retinal disorder ___ Other eye SX (list)
_____

Present Correction
___ Glasses ___ PMMA CL
___ Soft CL ___ RGP CL
Cls last worn _____

Pupil size OD_____ OS_____
Dominant eye OD/OS Currently mono Y/N
Corneal Diameter OD_____mm OS_____mm
Schirmer OD_____mm OS_____mm

Clinical Data

Distance
Va sc OD 20/___ Va cc OD 20/___
OS 20/___ OS 20/___

Present Glasses
OD ____ ____ x _____ Add _____
OS ____ ____ x _____ Add _____

Manifest Refraction BCVA
OD ____ ____ x ____ 20/____ VD____
OS ____ ____ x ____ 20/____ VD____

Cycloplegic Refraction BCVA
OD ____ _____ x ____ 20/____ VD____
OS ____ _____ x _____ 20/____ VD____

Keratometry (or topography simK's)
OD ____ ____ x _____
OS ____ ____ x _____

External	OD	OS
Normal	___	___
Chalazion	___	___
Blepharitis	___	___

Cornea	OD	OS
Normal	___	___
Dry Eye	___	___
Dystrophy	___	___
Vascularization	___	___
Keratoconus	___	___
Stromal Scar	___	___
Guttata	___	___
AK	___	___
RK	___	___
AST (Advanced Surface Treatment)	___	___
ALK	___	___
Lasik	___	___

Anterior Seg.	OD	OS
Clear	___	___
Cell/flare	___	___

Lens Status	OD	OS
Clear	___	___
NS cataract	___	___
PSC cataract	___	___
Cortical cataract	___	___
PCIOL/ACIOL	___	___

Procedure Request Sequence

LASIK _____ _____ OD 1st

AST
_____ _____ OS 1st

Corneal Topography

_____ completed _____ surgeon to perform

IOP OD _____ mmHg OS _____ mmHg

Doctor's Signature

X_____

Comments: