Refractive Surgery Preoperative Examination

Front Desk

Patient Name _____

Rank _____ **Age** _____ **Job** _____ **Date** _____

☐ **PRK** ☐ **LASIK** ☐ **RE-TREAT** **Other** _____

1. Questionnaire (every study, check completion) _____ **ALPS (comp study)** _____

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2. Medical Hx / Meds _____ **3. Allergies** _____

3. CL Hx ☐ **N/A** ☐ **DWSCL** ☐ **EWSCL** ☐ **RGPCL (see doc)**

4. Dominant Eye _____ **Notes:**

Ophthalmic Technician

	Right	Left
5. Present Rx (_____) how old?	_____ - _____ x _____	_____ - _____ x _____
6. Auto Refraction	_____ - _____ x _____	_____ - _____ x _____
7. Auto Keratometry	_____ x _____ @ ____	_____ x _____ @ ____
8. Uncorrected Visual Acuity	20/_____	20/_____
9. Manifest Refraction	_____ - _____ x _____	_____ - _____ x _____
10. Best Corrected Visual Acuity	20/_____	20/_____
11. 5% Contrast (low light)	_____	_____

Ophthalmic Tech

12. Pupil Size (low light) (device:_____)	_____	_____
13. Topography	_____	_____
14. Orbscan (comp study)	_____	_____
15. Wavefront (3 X/eye) (unit:_____)	_____	_____
16..Dilating drops	☐ **Mydriacyl 1%** ☐ **Cyclogel 1%**	@ _____
	Wait at least 20 minutes for testing	**(time)**
17. Dilated WF (3 X/eye) (unit:_____)	_____	_____

Ophthalmic Tech

18. Auto Refraction	_____ - _____ x _____	_____ - _____ x _____
19. Cycloplegic Ref	_____ - _____ x _____	_____ - _____ x _____
20. Pachymetry (LASIK/INTACS)	_____ , _____ , _____	_____ , _____ , _____
21. Intraocular Pressure	_____	_____ @_____ **(time)**

Doctors' Examination / Comments

22. Slit Lamp Exam:

☐ **Normal exam, OR ⇒**

23. Fundus/Retina:

☐ **Normal optic nerve OR ⇒**

☐ **Normal macula OR ⇒**

☐ **Normal periphery OR ⇒**

Notes/Plan:	**YES**	**NO**	**N/A**
Stable refraction	☐	☐	
Able to meet followup requirements (study)	☐	☐	☐
Flight Status	☐	☐	
Preop checklist complete	☐		
Cleared for surgery/study enrollment	☐	☐	

☐ **Not treatable at this time due to:**

☐ **Requires the following before surgery:**

Additional Notes:

Investigator _____