



Refractive Surgery Evaluation

FAX to 913-897-9233

Patient Name _____ M F Age _____ Birth date _____ Exam Date _____

Street Address _____ City _____ State _____ Zip Code _____

Home Phone Number _____ Work Phone Number _____ Comanage / Referral Dr. _____ Doctor Phone _____

E-Mail _____ Occupation: _____ Hobbies: _____

How did you hear about us _____ **Ocular History** NONE **Medical History** NONE
 Newspaper Radio Phone Book Ophthalmologist/Optomtrist RK ALK AK LASIK LASEK PRK IOL Rheumatoid Arthritis Diabetes Lupus
 Friend/Relative/Other _____ Cataract Glaucoma Other _____ Sjogren Syndrome Other _____

Presently Wearing _____ **Contact Duration** _____ **Contacts Last Used** _____
 No Correction Glasses Soft CL Gas Permeable < 1 year 1-5 years > 5 years 3 days 2 weeks Other _____

Glasses Prescription _____ **How Old** _____ **Drug Allergies:** NKDA **Other** _____
OD _____ **Add** _____ **Eye Medications** _____
OS _____ **Add** _____ **Medications** (Accutane, Imitrex, Tamoxifen, Amiodarone) _____
 VA sc OD 20/ J _____ cc OD 20/ J _____
 OS 20/ OS 20/

Manifest Rx OD _____ 20/ **Dominant Eye** OD OS **Schirmers Test** _____ mm / 5 min.
 OS _____ 20/ **Tonometry** OD _____ OS _____ _____ mm / 5 min.

Cyclo Rx OD _____ **Dilation:** <30 Cyclo 1% **Pupil Size (mm)** OD OS **PERRL** **APD**
 OS _____ >30 M & N (room light) _____ (dim light) _____ (circle one)

Keratometry OD _____ **Slit Lamp Exam** OD OS
 OS _____ External / Lids wnl

Pachymetry OD _____ OS _____ **ACD** OD _____ **Conjunctiva** wnl
 Orbscan Ultrasound (circle one) OS _____ **Cornea** wnl

Repeat MRx OD _____ 20/ **AC** wnl
 OS _____ 20/ **Lens** wnl

Impression OD Myopia Hyperopia Astig Presbyopia Amblyopia Cataract DES **Disc** wnl
 OS Myopia Hyperopia Astig Presbyopia Amblyopia Cataract DES **Macula** wnl

Plan OD ZYOPTIX LASIK EPI-LASIK / PRK LRI CK Ref IOL Phakic IOL Cat Sx Punctal plug **Periph** wnl
 OS ZYOPTIX LASIK EPI-LASIK/ PRK LRI CK Ref IOL Phakic IOL Cat Sx Punctal plug

Signature of Dr. performing preop exam _____

OD surgical plan OZ: _____ **OS surgical plan** OZ: _____
 Plate: 200 180 160 Plate: 200 180 160
 Ring: 8.5 9.5 Ring: 8.5 9.5

Target: Plano -1.00 Other _____ **Ablation Depth** _____ **Target: Plano -1.00 Other** _____ **Ablation Depth** _____
 Residual _____ Residual _____

Surgeon Signature: Timothy B. Cavanaugh, MD _____ (initial) **Date of Procedure:** _____ **See Back Page**
 Dictate? Y N **Dict Done?** Y N **e-mailed** _____