LASIK / PRK Pre-Op Co-Management Form Surgeon: Binoy R. Jani, MD

Exam Date: _____ Co-Managing Doctor: _____

Patient Information:

Name: _____ Occupation: _____ Birth Date: _____ Age: ____ Sex: M / F

Past Ocular History (including surgeries/injuries): _____

Past Medical History: _____

Medications/Eye drops:_____

Family History: _____ Allergies:_____

Have you had or been told of any of the following (please circle all that apply)? Diabetes, Lupus, Arthritis, Sarcoid, Dry Eyes, Keratoconus, Herpes Infection of the eye, Glaucoma, Corneal Erosion/Abrasion, Iritis/Uveitis, Cataracts, Problems with Contact Lenses (contact lens intolerance), Systemic Allergies, Auto Immune Diseases, NONE of the listed

Pre-Operative Exam: Auto Refraction: OD: _____ x _____ OS:_____ x _____

Operative Eye(s): _____ Soft / Toric / Gas Perm Lenses? (circle one) If yes how long? _____Last worn: _____

Dominant Eye: R / L Age of present glasses? _____ Refraction history (stable)? _____

		OD	OS
Uncorrected Vision:	Distance	20/ _____	20/ _____
	Near	20/ _____	20/ _____
Glasses Rx (Vision):	Distance	_____ x _____ = 20/ _____	_____x_____ = 20/_____
	Near	20/ _____	20/ _____

CVF: Full or _____ Motility: Normal or _____ Muscle Balance: Dist. _____ Near _____

Manifest Refraction:		_____ x _____= 20/ _____	_____x_____ = 20/____
(Vision)		Vertex: _____ mm	Vertex: _____ mm
Pupils:		Light _____ mm	Light _____ mm
		Dark _____ mm	Dark _____ mm
Cycloplegic Refraction:		_____ x _____ = 20/ _____	_____x_____ = 20/____
Central Keratometry (K's):		_____@ _____	_____@ _____
		Steepest (D) Axis	Steepest (D) Axis
		_____@ _____	_____@ _____
		Flattest (D) Axis	Flattest (D) Axis
Central Pachymetry:		_____	_____
IOP:		_____ mm Hg	_____ mm Hg

☐ Consent given to patient to take home and review ☐ Antibiotic Rx given to patient

Slit Lamp Exam / Dilated Fundus Exam:

Shirmer's Testing: OD: _____ OS: _____ C/D: OD: _____ OS: _____

Lids/Lashes/Lacrimal: Normal OU or _____ Macula: Normal OU or _____

C/S: Normal OU or _____ Vessels: Normal OU or _____

Cornea: Normal OU or _____ Periphery: Normal OU or _____

A/C: Normal OU or _____ Retinoscopy: Normal OU or _____

Lens: Normal OU or _____ A/P:

Laser Treatment Plan: Myopia _____ Astigmatism _____ Hyperopia _____ Monovision Y N Slight

Large Ablation Zone? Y N Blend Zone? Y N Deep Set Eyes ? Y N Blepharospasms (squeezer)? Y N

Keratoconus / Forme Fruste / Corneal Ectasia discussed: Yes ____ No ____

Presbyopia discussed: Yes ____ No ____

Glares/Halos discussed: Yes ___ No ____

	OD	OS
Desired Outcome	_____	_____