INSIGHT LASIK & Refractive Group
A Division of Scott & Christie and Associates

Affiliate Partner Practice:

REFRACTIVE PRE-OP / CONSULT EVALUATION FORM Date:____/____/_____

Patient Name:_____ Date of Birth: _____

Allergies:_____ Medications:_____

_____

_____**Patient is not Pregnant**

_____**Patient is not Allergic**
(or is unaware of allergy) to Latex

_____**Patient denies having Hepatitis or HIV**

_____**Patient denies having Defibrillator**

WaveScan:
OD: _____
OS: _____

Autorefraction:
OD: _____
OS._____

POH:
FHX:
Social HX: Tobacco: _____ ETOH: _____ Activities/Hobbies: _____

CC/HPI:_____
_____
_____

VASC: OD:__/__ **J:** OD: _____ **BCVA:** OD:__/__ **J:** OD: _____ Contact Lens Hx:
OS:__/__ OS: _____ OS: __/__ OS: _____ _____
Last Worn: _____

PC: OD: _____ 20/__
OS: _____ 20/__

MR: OD: _____ 20/__
OS: _____ 20/__

CR: OD: _____ 20/__
OS: _____ 20/__

Pupils: ERRL __ APD __ Size __
Motilities: Intact/Restricted _____
Conf VF: Full/ Restricted _____
Horizontal W / W: _____
Zone Quick: _____

Tap: OD: ____ OS: ____
Dilation gtts: Cyclogel @ _____
1% x 2, 1 min apart

	WNL	Abnormal Descrption:
L/L/L		
Conjunctiva		
Cornea		
A/C		
Lens		
C/D		
Vitreous		
Macula		
Periphery		

TX: OD: _____ Ring: _____/140
OS: _____

R / B / A Discussed Including:
_____ Glare / Halos
_____ Infection
_____ Haze
_____ Dryness
_____ Over/Under Correction
_____ Need for Readers
_____ Flap Complications
_____ Demonstrated 20/40
_____ Possible Future Need for Enhancements
_____ PRK: Pain, FBS, Delayed VA Recovery