TURNER EYE INSTITUTE

(800) 339-2733
www.turnereye.com

- San Leandro
- Santa Clara
- Concord

REFRACTIVE SURGERY ASSESSMENT

Date: _____/_____/ 20____

Referring Dr. _____ Surgeon _____

Patient Name _____ DOB _____/_____/_____

Address _____ WK Phone (_____) _____-_____

City / State / Zip _____ HM Phone (_____)_____-_____

Comanagement discussed and requested by the patient (circle): Y N **Patient Desires:** ☐LASIK ☐PRK

☐INTRALASIK ☐Epi-LASEK ☐W/ Wavefront ☐Intacs ☐Phakic IOL ☐Crystalens

Other: _____ Laser Center preferred (city): _____

Assessment

Ocular History: (e.g. injury, amblyopia, previous surgery, problems with lens wear, etc…) _____

_____

Medical History: ☐ diabetes ☐ hypertension ☐ asthma ☐ collagen vascular disorder

☐ other: _____

Medication: Ocular _____ Systemic _____

Allergies: _____ Present Correction: ☐ Glasses ☐ Contacts

Rx Stable for_____ years

Contact Lenses: ☐ Soft Daily Wear ☐ Soft Extended Wear ☐ RGP

VAsc **OD** 20/_____ **OS** 20/_____ **Near** VAcc **OD**_____ **OS** _____

PLEASE PRINT CLEARLY	**OD**	**VA**	**OS**	**VA**
Manifest Refraction	_____	____	_____	____
Cycloplegic Refraction	_____	____	_____	____
Keratometry Readings Circle (Auto / Manual)	_____ @ _____ _____ @ _____		_____ @ _____ _____ @ _____	

Intraocular Pressure (circle: Apl. / NCT / Tonopen) OD _____ OS _____ mm/Hg Pupil Size (dim) OD_____ OS_____

Ocular Motility / Pupil Exam Normal / Other _____ Normal / Other _____

Anterior Segment and Fundus Normal / Other _____ Normal / Other _____

Dominant Eye (circle): R L _____ _____

Monovision Desired (circle): Y N Pachymetry: CCT OD:_____ OS _____

Monovision Target:_____

One Day Post-op to be done by: ☐ Co-managing Doctor ☐ Surgeon

Please fax to (510) 357-6330 Assessing Doctor: _____