EYE CENTER OF TEXAS

Fax to 713-357-7278

Pre-Procedure Report

Patient: *(last)*_____ *(first)*_____ *(MI)*_____ Date: _____

Home Phone: _____ Work Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ Sex: M F TDL#: _____ SS# _____

Physician: _____ Tech: _____

Patient's Expectation: Unreasonably High High Reasonable Low Unknown

CC: _____

POH: _____

CL Hx: Type: RGP SDW SEW Other: _____ Date Last Worn: _____

PMH: _____

MEDS: _____

F/SH: Occupation: Hobbies:

	SPH	CYL	AXIS	ADD	Vcc	Vcc OU	Vsc	Vsc OU	Vsc Near	Vcc Near	PUPILS
HAB					20/	20/	20/	20/	J	J	Size – Dim: OD____mm OS____mm
					20/		20/		J	J	Size – Bright: OD____mm OS____mm
DRY					20/	K	OD_____				Rxn: NL ABNL
					20/		OS _____				Color_____
CYCLO				20/	TOPO	CYL	AXIS	CYL TYPE	TOPOGRAPHY		
				20/				Sym Asym Irr	❑ Attached	T	
	Dominant Eye: OD OS							Sym Asym Irr	❑ Perform at Laser Ctr		Time:

Slit Lamp Examination:

☐ OD – Lids, Conj, Cornea, A/C, Lens All normal except as noted ☐ OS – Lids, Conj, Cornea, A/C, Lens All normal except as noted

NOTED:

Internal Examination:

☐ OD – Vitreous, ON, Vessels, Retina All normal except as noted ☐ OS - Vitreous, ON, Vessels, Retina All normal except as noted

NOTED:

ASSESS: _____

_____

PLAN: _____

_____

PROCEDURE: LASIK PRK PTK None Other:_____

REFRACTIVE AIM: OD_____ OS _____ MONO: Yes No

PROCEDURE DATE: OD _____ OS _____ OU _____

POST-PROCEDURE CARE: Primary Doctor: _____

Patient has received and understands the following:

☐ Information Manual ☐ Informed Consent ☐ Post-Procedure Care / Fees

Physician: _____ Assistant _____

Please send to Eye Center Of Texas At 6565 West Loop South, Suite #650, Bellaire, TX 77401 at Fax: 713.357.7278

☐ Faxed ☐ Mailed to **Eye Center Of Texas** on *(date)*_____ by *(init.)*_____

Revised: 03/09/2006