PRE-PROCEDURE REPORT

FAX TO 713-357-7278

PATIENT Last ______________________ First ______________________ MI ________ **DATE** ________

PHONE Home ______________________ Cell ______________________ Work ______________________

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 ______________________

<table>
<tr><th></th><th>SPH</th><th>CYL</th><th>AXIS</th><th>ADD</th><th>Vcc</th><th>Vcc OU</th><th>Vsc</th><th>Vsc OU</th><th>Vsc Near</th><th>Vcc Near</th></tr>
<tr><td rowspan="2">HAB</td><td></td><td></td><td></td><td></td><td>20/</td><td rowspan="2">20/</td><td>20/</td><td rowspan="2">20/</td><td>J</td><td>J</td></tr>
<tr><td></td><td></td><td></td><td></td><td>20/</td><td>20/</td><td>J</td><td>J</td></tr>
<tr><td rowspan="2">DRY</td><td></td><td></td><td></td><td></td><td>20/</td><td rowspan="2">K</td><td colspan="4">OD ______________________</td></tr>
<tr><td></td><td></td><td></td><td></td><td>20/</td><td colspan="4">OS ______________________</td></tr>
<tr><td rowspan="2">CYCLO</td><td></td><td></td><td></td><td>20/</td><td rowspan="3">TOPO</td><td>CYL</td><td>AXIS</td><td>CYL TYPE</td><td colspan="2">TOPOGRAPHY</td></tr>
<tr><td></td><td></td><td></td><td>20/</td><td></td><td></td><td>Sym Asym Irr</td><td colspan="2">☐ Attached</td></tr>
<tr><td colspan="5">Dominant Eye: OD OS</td><td></td><td></td><td>Sym Asym Irr</td><td colspan="2">☐ Perform at Laser Ctr</td></tr>
</table>

PUPILS

Size — Dim
OD ___mm OS ___mm

Size — Bright
OD ___mm OS ___mm

Rxn: NL ABNL

Color ____________

T	
	Time

SLIT LAMP EXAMINATION

☐ **OD** – Lids, Conj, Cornea, A/C, Lens All normal except as noted.
NOTED:

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

INTERNAL EXAMINATION

☐ **OD** – Vitreous, ON, Vessels, Retina All normal except as noted.
NOTED:

☐ **OS** – Vitreous, ON, Vessels, Retina All normal except as 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 ______________________

TOTAL LASIK FEE $ ______________

Physician ______________________ Assistant ______________________

PLEASE SEND TO EYE CENTER OF TEXAS AT 6565 WEST LOOP SOUTH, SUITE 650, BELLAIRE, TEXAS 77401

☐ Faxed #713-357-7278 ☐ Mailed on *(date)* ____________ by *(intials)* ________

EYE CENTER OF TEXAS
Leaders in Eye Care

Revised 5/2023