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