BLACK HILLS REGIONAL EYE INSTITUTE

Laser Vision Correction Evaluation

_____ _____/_____/_____ _____ _____

First Name M.I. Last Name Date of Birth Sex Acct #

_____-_____-_____ _____ _____ _____/_____/_____

Phone Number Occupation Referring OD Date

History CC/HPI:_____

_____

_____

ROS/PFSH REVIEWED: NO CHANGE SINCE _____

REVIEW OF SYSTEMS (ROS): Reviewed By_____

Y	N	
❑	❑	CONSTITUTIONAL_____
❑	❑	EYES_____
❑	❑	EARS, NOSE, MOUTH, THROAT_____
❑	❑	CARDIOVASCULAR_____
❑	❑	RESPIRATORY_____
❑	❑	GASTROINTESTINAL_____
❑	❑	GENITOURINARY_____
❑	❑	INTEGUMENTARY_____
❑	❑	MUSCULOSKELETAL_____
❑	❑	NEUROLOGICAL_____
❑	❑	HEMATOLOGIC/LYMPHATIC_____
❑	❑	ALLERGIC/IMMUNOLOGIC_____
❑	❑	ENDOCRINE_____
❑	❑	OTHER_____

SOCIAL HISTORY:

Y	N	
❑	❑	DRUGS_____
❑	❑	ALCOHOL_____
❑	❑	TOBACCO_____

FAMILY HISTORY:

❑ Nonpertinent ❑ Pertinent _____

CORRECTIVE LENSES:

❑ HCTL ❑ GPCTL Last Worn:_____

❑ SCTL ❑ GLASSES Years Worn:_____

CONTRAINDICATIONS (RELATIVE):

Y	N	
❑	❑	Dry Eyes
❑	❑	Glaucoma
❑	❑	Rx Change in 12 mo
❑	❑	Diabetes Mellitus
❑	❑	Inflammatory Corneal Disease

ALLERGIES:

_____

_____

MEDICATIONS:

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY:

_____

_____

_____

_____

_____

PAST OCULAR HISTORY / OPHTHALMIC MEDICATIONS:

_____

_____

_____

_____

_____

GOAL:

_____

_____

CONTRAINDICATIONS (ABSOLUTE):

Y	N		Y	N	
❑	❑	External Disease	❑	❑	Hx of Herpes Simplex
❑	❑	Keratoconus	❑	❑	Irregular Astigmatism
❑	❑	Active Ocular Infection	❑	❑	Connective Tissue Disease
❑	❑	Recurrent Corneal Erosion	❑	❑	Corneal Abrasion

Name_____

Date of SCREENING: _____

Current Rx

O.D._____SPH _____CYL _____Axis
O.S._____SPH _____CYL _____Axis

VAsc O.D. 20/_____ **Near** O.D. 20/_____
O.S. 20/_____ O.S. 20/_____

VAcc O.D. 20/_____ **Near** O.D. 20/_____
O.S. 20/_____ O.S. 20/_____

Keratometry

O.D.K1_____K2_____K2Axis_____

O.S.K1_____K2_____K2Axis_____

Manifest Refraction

O.D._____SPH _____CYL _____Axis 20/____
O.S._____SPH _____CYL _____Axis 20/____
Add Power _____

Pupils (mm)

O.D. light_____ O.D. dark_____
O.S. light_____ O.S. dark_____

Pachymetry

O.D._____ O.S._____

❑ Reviewed Level of Correction
❑ Reviewed Pupil Size
❑ Reviewed Corneal Shape & Thickness

Diagnosis/Plan

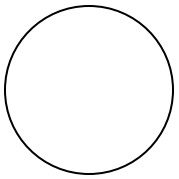
BHREI to call _____
❑CK ❑CRYSTALENS ❑CUSTOM LASIK ❑LASIK
❑IOL: PHAKIC / ACCOMMODATING

_____
Signature

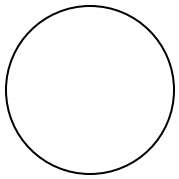
Dominant Eye _____

Date of PRE-OP: _____

WNL O.D.
❑ lids/lashes
❑ conj
❑ cornea
❑ iris
❑ a/c
❑ lens



WNL O.S.
❑ lids/lashes
❑ conj
❑ cornea
❑ iris
❑ a/c
❑ lens



IOP

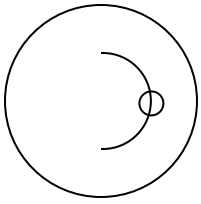
O.D._____ mmHg O.S._____ mmHg

Cyclo 1% @ _____

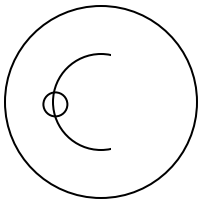
Cycloplegic Refraction

O.D._____SPH _____CYL _____Axis 20/____
O.S._____SPH _____CYL _____Axis 20/____

Fundus WNL O.D.
❑ macula
❑ periph
_____ c:d



Fundus WNL O.S.
❑ macula
❑ periph
_____ c:d



Diagnosis/Plan

❑Reviewed Informed Consent DVD_____
❑Reviewed Instructions_____
❑Discussed expectations, risk/benefit, enhancement _____

_____
Signature

Please fax to Black Hills Regional Eye Institute Laser Vision Center 605-719-3330