WLEI Windsor Laser Eye Institute
A Tayfour Clinic

# Pre-operative Evaluation

Exam Date:_____

Doctor Name: _____ Contact: _____ Phone:_____

Patient Name: _____ Birthdate: _____Age: _____

Address:_____ City: _____Prov:_____Postal: _____

Phone: _____Day: _____ Gender: ☐ Male ☐ Female

Hx of Corrective Eyewear: _____

**UCVA** OD 20/ _____ OS 20/ _____ Dominant Eye: ☐ ☐ Monovision: ☐ Yes ☐ No

## Glasses Rx

| | SPHERE | CYL. | AXIS | | | SPHERE | CYL. | AXIS | |
|---|---|---|---|---|---|---|---|---|---|
| OD | | | | 20/ | OS | | | | 20/ |

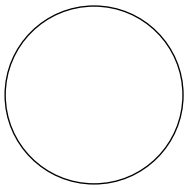
## Subjective Refraction

| | SPHERE | CYL. | AXIS | | | SPHERE | CYL. | AXIS | |
|---|---|---|---|---|---|---|---|---|---|
| OD | | | | 20/ | OS | | | | 20/ |

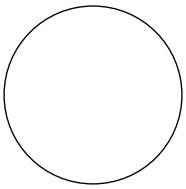
## Cycloplegic Refraction (No cyclo for CXL-UVA)

| | SPHERE | CYL. | AXIS | | | SPHERE | CYL. | AXIS | |
|---|---|---|---|---|---|---|---|---|---|
| OD | | | | 20/ | OS | | | | 20/ |

## Slit Lamp Exam

OD 

Cornea: _____
A.C.: _____
Iris: _____
Lens: _____
Fundus: _____
_____ I.O.P._____
_____ mm.Pupil (dim) _____mm

 OS

## History

Prior Ocular Surgery: _____ Health Problems: _____

Medications: _____ Allergies to Meds: _____

☐ Diabetes ☐ Herpes Simplex ☐ Lupus ☐ Rheumatoid Arthritis ☐ Keloid Formation ☐ Other _____

## Status

Surgery Date:_____ CXL-UVA ☐ **Intralase** ☐ Yes ☐ No

Doctor Comments: _____

_____

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