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: OD OS Monovision: Yes ☐ No ☐

Glasses RX

	SPHERE	CYL.	AXIS		SPHERE	CYL.	AXIS	
OD				20/				20/

Subjective Refraction

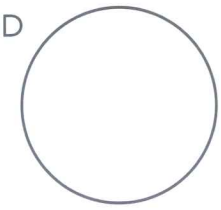
	SPHERE	CYL.	AXIS		SPHERE	CYL.	AXIS	
OD				20/				20/

Cycloplegic Refraction (No cyclo for CXL-UVA)

	SPHERE	CYL.	AXIS		SPHERE	CYL.	AXIS	
OD				20/				20/

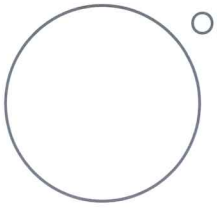
Slit Lamp Exam

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 ☐ Keloid Formation ☐ Other _____

Status

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

Doctor Comments: _____

_____

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