LASIK/PRK/SMILE Preoperative Measurements

Patient Name: ______________________________ ❑ M ❑F Date: ____________

Co-managing O.D.: __________________ ❑N/A D.O.B.: _____/_____/_____ Age: _____

Motivation: ❑Contact Intolerance ❑Cosmetic ❑Lifestyle ❑Occupation ❑Other ____________

C/L Wearer: ❑Yes ❑No Type: __________ Date Last Worn: __________ Mono C/L: ❑Yes ❑No

Past Ocular History: ______________________ Eye Medication: ____________________

Medical History: ______________________ Occupation: ____________________

Medications: ______________________ Hobbies: ____________________

Allergies: ❑NKDA __________

System Review: ❑Diabetes ❑Rheumatoid Arthritis ❑Retinal Tear ❑Recurring Red Eye ❑Pregnant ❑Nursing

❑Dry Eye ❑Eye rubbing ❑Ocular Herpes Ocular Dominance: ❑O.D. ❑O.S.

OD **OS**

____________________ 20/_____ J_____ W Rx ____________________ 20/_____ J_____Add_____

20/__________ J_____ VASC 20/__________ J_____ OU 20/_____ J_____

__________ Scotopic Pupils (Colvard) __________

____________________ 20/_____ MR (__________OD/ Tech.) ____________________ 20/_____

____________________ Monovision Trial ____________________ ❑likes ❑dislikes

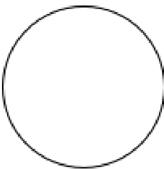
____________________20/_____ BAT (Med.) ____________________20/_____

(Dilation time:__________am/pm)

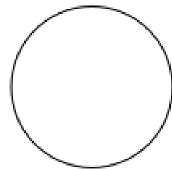
____________________20/_____ CR (gtt: ____) ____________________ 20/_____

____________________20/_____ Re√ MR ____________________ 20/_____

Schirmer's:



Re√ MR Date:__________ O.D./Tech:__________



SLE

__________ Lids __________

__________ Corneal Status __________

__________ Lens __________

__________ Fundus __________

__________ mm/Hg IOP __________ mm/Hg

__________ Manual Pachy. __________

__________ Goal __________

TBUT:
OD _____

OS _____

LASER:
Visx Nidek Wave Smile
KERATOME:
Ziemer MK Visumax
HINGE: nasal
FLAP DEPTH:
100 110 130 160 ____
FLAP DIAMETER:
8.5 8.8 9.0 9.5
O.Z.:__________

Physician Notes:
____
____
____
____

____________________ Procedure ____________________

____________________ True Rx ____________________

____________________ Treatment Rx ____________________

____________________ Laser Input ____________________

Informed Consent: Discussed Potential risks and side effects including: ____________________

____

______________________________Signature: ____________________ updated 04/2017

(805) 987-5300
4333 Park Terrace Drive
Westlake Village, CA 91362
www.doughertylaservision.com

9100 Wilshire Blvd., Ste 265E
Beverly Hills, CA 90212

835 Aerovista Lane, #110
San Luis Obispo, CA 93401

1821 E. Daily Dr.
Camarillo, CA 93010

2796 Sycamore Dr., Ste 101
Simi Valley, CA 93065

16130 Ventura Blvd., Ste 120
Encino, CA 91436

4353 Park Terrace Dr., Ste150
Westlake Village, CA 91361