

DOCTOR INFORMATION

Name _____
 Clinic Name _____
 Email _____
 Phone _____
 Fax _____



CLEAR VISION SURGICAL

KITCHENER-WATERLOO

P 226-499-2021 | F 226-499-3021

SURGEON PREFERENCE

DR. ALANGH

DR. DESAI

DR. WILKINSON

FIRST AVAILABLE

PATIENT INFORMATION

Patient Name _____ Date of Birth _____ Gender **M** **F**
 Email _____ Phone _____ **H** **W**
 Address _____

REFERRAL FOR: **LASIK** **PRK** **CATARACT** **RLE** **ICL** **CXL** **YAG** **OTHER** _____

EYE HISTORY

Any History of Contact Lens Use? **Y** **N** Soft Hard Successful Wearer? **Y** **N**
 Last Worn _____ If no, why? _____
 Reading Correction with CL \pm _____ MONO **Y** **N**

EYE HEALTH *None of the below or select all that apply:*

Trauma Glaucoma Retinal or Optic Nerve Disease HSV or HZO Cataracts Strabismus
 Amblyopia Keratoconus or FH Prior Refractive Surgery Any Eye Surgery

GENERAL HEALTH

Allergies _____ Latex Allergy **Y** **N** Anaesthetic Difficulties **Y** **N**
 Medications _____ Pacemaker **Y** **N** Pregnant or Nursing **Y** **N**

HEALTH CONDITIONS *None of the below or select all that apply:*

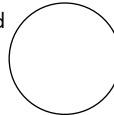
Uncontrolled Diabetes Rheumatoid Arthritis Psoriatic Arthritis Lupus Fibromyalgia Crohn's MS
 Ankylosing Spondylitis Cancer Scleroderma AIDS Other Immune Compromised Conditions
 Other _____

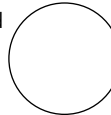
REFRACTION

Dry: OD _____ 20 / OS _____ 20 / ADD _____
 Wet: OD _____ 20 / OS _____ 20 /
 Stability: Has there been more than 0.50 D change in past year? **Y** **N**

CLINICAL EXAMINATION

Slit Lamp Exam

OD
 Lids / Lashes: Clear Blepharitis
 Conj: White Injected 
 Cornea: Clear
 Neo: _____ / 4 +
 Dry Eye (Schirmer, TBUT): _____

OS
 Lids / Lashes: Clear Blepharitis
 Conj: White Injected 
 Cornea: Clear
 Neo: _____ / 4 +
 Dry Eye (Schirmer, TBUT): _____

Fundus Exam

OD
 Lens: _____
 Disc: _____
 Macula: _____
 Periphery: _____
 IOP: _____

OS

Comments _____

Signature _____ Date _____