DOCTOR INFORMATION

Name _____

Clinic Name _____

Email _____

Phone _____

CLEAR VISION SURGICAL
KITCHENER-WATERLOO

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

SURGEON PREFERENCE

☐ DR. ALANGH ☐ DR. DESAI ☐ DR. GULAMHUSEIN ☐ DR. WILKINSON
☐ DR. MOINUL ☐ DR. RODRIGUEZ ☐ DR. XU ☐ FIRST AVAILABLE

PATIENT INFORMATION

Patient Name _____ DOB (MM/DD/YY) _____ Gender ☐ M ☐ F ☐ Other

Email _____ Phone _____ ☐ H ☐ W

Address _____

Mobility Status ☐ Walking ☐ Walker/Device ☐ Wheelchair - Can Patient Transfer? ☐ Y ☐ N

REASON FOR REFERRAL

☐ LASIK ☐ PRK ☐ CATARACT ☐ RLE ☐ ICL ☐ CXL ☐ YAG ☐ OTHER _____

OCULAR HEALTH & HISTORY

Any History of Contact Lens Use? ☐ Y ☐ N ☐ Soft ☐ Hard Successful Wearer? ☐ Y ☐ N

Last Worn _____ If no, why? _____

Reading Correction with CL ____ + _____ MONO ☐ Y ☐ N

Prior Refractive Surgery? ☐ Y ☐ N If yes, please describe _____ ☐ HYPEROPIC ☐ MYOPIC

Ocular History _____

GENERAL HEALTH

Medications _____ Allergies _____

◯ Pregnant or Nursing ◯ Diabetes ◯ Hypertension ◯ HIV/AIDS ◯ Hepatitis ◯ Rhumatoid Arthritis ◯ Lupus ◯ Fibromyalgia

☐ Other Immune Compromised Conditions ☐ Other _____

REFRACTION

Dry (Current): OD _____ 20 / OS _____ 20 / ADD _____

Dry (Previous): OD _____ 20 / OS _____ 20 / ADD _____

Wet: OD _____ 20 / OS _____ 20 /

For Lasik or PRK Referrals - Stability: Has there been more than 0.50 D change in past year? ◯ Y ◯ N

CLINICAL EXAMINATION

Slit Lamp Exam

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

Fundus Exam

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

Was this a dilated eye exam? ☐ Y ☐ N

Comments _____

_____

Signature _____ Date _____