Print Form

Grand Valley LASIK Institute

Laser Vision Correction Pre-Op

Patient Information

Last Name	First Name	MI
Address	City	State/Province Zip/Postal Code
Evening Phone & Area Code	Daytime Phone & Area Code	Occupation
Birth Date / / Age Eye Color	Sex M☐ F☐	
	Fee quoted per eye	Date of Exam / /

Medical & Ocular History

Medical Conditions	Ocular Conditions (previous eye surgeries, refractive procedures, diseases, injuries)
Current Medications (if applicable)	Allergic Reactions (medications, solutions)
Contact Lens Use ☐PMMA ☐RGP ☐TORIC SCL ☐DWSCL ☐EWSCL	Time out of CL's

Procedure Assessment

	OD	OS
Unaided Visual Acuity	20/	20/
Best Corrected Visual Acuity	20/	20/
Manifest Refraction	20/	20/
Cycloplegic Refraction	20/	20/
Stable Refraction	Mos Yrs Unknown☐	Mos Yrs Unknown☐
Keratometry	Flat @ Axis Steep @ Axis	Flat @ Axis Steep @ Axis
IOP	mmHG @	mmHG @
Slit Lamp	Lids ☐ wnl comment: Cornea ☐ wnl comment: AC ☐ wnl comment: Lens ☐ wnl comment:	Lids ☐ wnl comment: Cornea ☐ wnl comment: AC ☐ wnl comment: Lens ☐ wnl comment:
Pupil Diameter	(mm) Dim (mm) Bright Illumination	(mm) Dim (mm) Bright Illumination
Fundus	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
C/D		
Peripheral Retina	normal / lattice / pavingstone / RD / holes	normal / lattice / pavingstone / RD / holes
Recommended Procedure	☐ Custom ☐ Conventional ☐ LASIK ☐ Enhancement ☐ PRK	☐ Custom ☐ Conventional ☐ LASIK ☐ Enhancement ☐ PRK
Monovision	☐ Yes ☐ No	Dominant Eye ☐ OD ☐ OS
Desired Outcome		

Comments/Questions

Doctor Information ☐ OD ☐ MD ☐ DO

Name	Phone	Fax
Signature		Date