HORIZON EYE SPECIALISTS & LASIK CENTER

Laser Vision Correction – Co-management Pre-Operative Visit
Please fax Pre-Operative form to our office. Fax# 480.419.5401
Contact: Shelby 480.513.6554

Patient's First Name _____ Last Name_____

Home Ph# _____Work Ph#_____Cell Ph#_____

DOB _____ ☐ Male ☐ Female

Co-Manage Dr. _____ Office #_____

Reason for considering Refractive Surgery: _____

Allergies: _____Current Meds:_____

Medical HX: _____

Ocular HX: _____Previous Eye SX:_____

Family Ocular HX: _____

Contact lenses _____ RGP (out for 4 wks) _____SCL (Sph out for 3 days, Toric out for 7 days)

Current RX: OD _____ 20/_____ Add _____ 20/_____

OS _____20/ _____ Add _____20/_____

Vision: OD SC 20/_____IOP: OD: _____ PACHS: OD: _____Pupil Size: Dim_____

OS SC 20/_____ OS: _____ OS: _____ Bright_____

Refraction: MRx: OD_____20/_____ K Readings: _____

OS_____20/_____ K Readings: _____

Cyclo: OD_____20/_____

OS _____20/_____

Dominate Eye: _____ Vertex Distance: _____

Biomicroscopy	OD	OS	Ophthalmology	OD	OS
Lids/lashes			C/D ratio		
Conj			Macula		
Cornea			Vessels		
AC			Peripery		
Lens			Vitreous		

Recommendation/Plan: _____

Doctor Signature: _____Date: _____