DOCTOR INFORMATION

Name _____

Email _____

Phone _____

Fax _____

BURLINGTON
LASER EYE CENTRE
3305 Harvester Road., Burlington, ON • L9A 4V7
Tel: 888-636-4733 • Fax: 905-632-9778

PATIENT INFORMATION

Patient Name _____ Date of Birth ___/___/___ Gender M F

Email _____ Phone _____ H W

Address _____ Referral For: _____

CUSTOM ALL LASER LASIK / PRK / CATARACT / RLE / ICL / OTHER

EYE HISTORY

Any History of Contact Lens Use : Y / N SCL : RGP / PMMA Successful Wearer? Y N

Last worn _____ If No, why? _____

Reading Correction with CL + _____ / MONO

EYE HEALTH none of the below ◯ (or circle 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 circle all that apply)

Uncontrolled Diabetes / Rheumatoid Arthritis / Psoriatic Arthritis / Lupus / Fibromyalgia / Crohn's / MS

Ankylosing Spondilitis / 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

Date of Exam _____

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

Fundus Exam	OD	OS
Lens:		
Disc:		
Macula:		
Periphery:		
IOP:		

Comments _____

_____

Signature _____ Date _____