Please FAX this form to PACIFIC VISION INSTITUTE
(415) 922-9568
Attn: Comanagement Department

☐ **Hard Contact Lenses** have been removed for at least 2 weeks prior to this examination
☐ **Extended Wear Soft Contact Lenses** have been removed for at least 1 week prior to this examination
☐ **Daily Wear Soft Contact Lenses** have been removed for at least 48 hrs. prior to this examination

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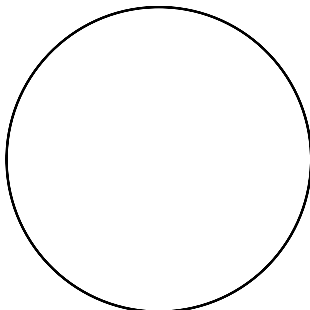
Pre-Operative Evaluation Form

Today's Date: ________________________

Patient's Name: ______________________	Co-Managing Doctor: ___________________
Address: ____________________________	Address: ______________________________
C/S/Z: ______________________________	C/S/Z: ________________________________
Phone: H) ____________________	Phone: ____________________
W) ____________________	Fax: ____________________
DOB: ________ SS#: _________________	Sex: ____________________
Past Ocular History: ___________________	Past Medical History: ____________________
Ocular Meds/Drops: ___________________	Meds: _________________________________

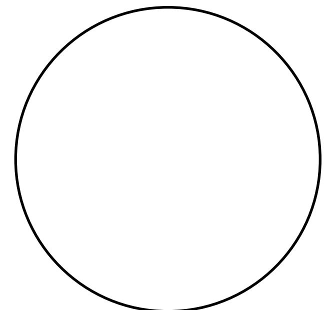
EXAM:

OD		OS
______________________	W Rx	______________________
20/__________ J__________	VA SC	20/__________ J__________
20/__________ J__________	VA CC	20/__________ J__________
________@________@________	K	________@________@________
____________20/____________	MR	____________20/____________
______________	Pupils	______________
yes or no	APD	yes or no
______________	EOM's	______________
______________	VF's	______________
______________	TA	______________



Anterior Segment

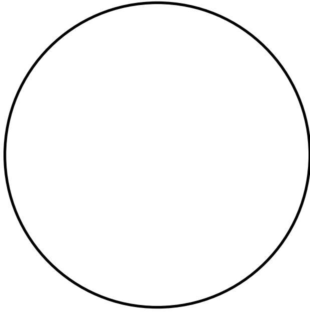
______________	Conj	______________
______________	Cornea	______________
______________	AC	______________
______________	Iris	______________



(Dilated @______w/ M1%, N2.5%, C1%)

____________20/____________	CR	____________20/____________

Fundus Exam



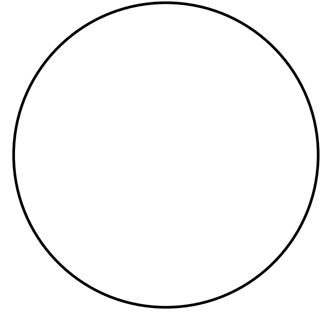
________________ Lens ________________

________________Vireous________________

________________ Disc ________________

________________Macula________________

________________Vessels________________



Assessment: ____

____

Plan: ____

____

Surgery Schedule: Yes / No Date (s): OD____________ OS_____________

Returning for Dilation: Yes / No Date: ____________________________________

Signature: (Comanaging Doctor): ____________________________________