9246 Lightwave Avenue Suite 120
San Diego, CA 92123

Phone: 858-694-0400
Fax: 858-565-7368

San Diego Eye Bank Excimer Laser Center

Patient Information

Patient Information

Surgery Date:_____

Name:_____ Date of Birth:_____

Address:_____ Sex:_____

Medical History Exam Date:_____

Known allergies: _____

Positive medical or surgery history: _____

Previous ocular surgery (OD, OS, OU): _____

_____

If your patient has any of the following conditions or is taking any of the listed medications, please circle.

Keratoconus, Collagen Vascular Disease, Autoimmune, Immunodeficiency Disease, Pregnant or Nursing, Taking Cordarone or Accutane

Pre-Operative Information - OD

Corneal haze: _____ VA-sc: _____ VA-cc: _____

Dominant Eye: ___ Yes ____No

Slit lamp exam: Normal / Abnormal **Dilated exam:** Normal / Abnormal

Pentacam/Topography: Normal / Abnormal **Pachometry:** _____

Diagnosis: Myopia / Hyperopia / Ast / Mixed / _____

Keratometry: K1_____AXIS_____ K2_____AXIS_____

	Sphere	Cylinder	Axis
Manifest:			
Cycloplegic:			
Correction Desired: or WaveScan Refraction:			
WaveScan Physician adj:			

WaveScan Nomogram Adj.:_____

Correction: (Circle all that apply)

PTK / PRK / LASIK / LASEK / CUSTOM / RETREAT / FLAP LIFT ONLY

Vertex Distance: 12.50 / _____mm **Hertz:** 8 10 _____

Blend Zone: Y N **Ablation Zone:** 6 / 6.5 / Hyp / Custom

PRK: Alcohol / Brush / Laser Scrape **MITO:** ____ Yes ____ No

Plate: 160 / 180 / 200 / _____ **Ring:** 8.5 / 9.5 / 8.5M / 9.5M

Intralase: Depth: _____ Diameter: _____

Pre-Operative Information - OS

Corneal haze: _____ VA-sc: _____ VA-cc: _____

Dominant Eye: ____Yes ____ No

Slit lamp exam: Normal / Abnormal **Dilated exam:** Normal / Abnormal

Pentacam/Topography: Normal / Abnormal **Pachometry:** _____

Diagnosis: Myopia / Hyperopia / Ast / Mixed / _____

Keratometry: K1_____AXIS_____ K2_____AXIS_____

	Sphere	Cylinder	Axis
Manifest:			
Cycloplegic:			
Correction Desired: or WaveScan Refraction:			
WaveScan Physician adj:			

WaveScan Nomogram Adj.:_____

Correction: (Circle all that apply)

PTK / PRK / LASIK / LASEK / CUSTOM / RETREAT / FLAP LIFT ONLY

Vertex Distance: 12.50 / _____mm **Hertz:** 8 10 _____

Blend Zone: Y N **Ablation Zone:** 6 / 6.5 / Hyp / Custom

PRK: Alcohol / Brush / Laser Scrape **MITO:** ____ Yes ____ No

Plate: 160 / 180 / 200 / _____ **Ring:** 8.5 / 9.5 / 8.5M / 9.5M

Intralase: Depth: _____ Diameter: _____

ALL AREAS MUST BE COMPLETED IF APPLICABLE PRIOR TO SURGERY

Physician's Signature:_____ Physician's Phone:_____

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INSTRUCTIONS

Standard PRK, LASIK, LASEK or PTK

All areas need to be completed except for WaveScan refraction, WaveScan physician adj and WaveScan completed: Y or N

CustomVue

All areas need to be completed, however when entering in the treatment, complete only WaveScan refraction or WaveScan physician adj. Do not use Correction Desired.