Shealy Eye Laser Examination Sheet

**Demographics**

| First Name | M. I. | Last Name | DOB | Phone | Date | MM# |
|---|---|---|---|---|---|---|
| | | | | | | |

| Street Address | City | State | Zip |
|---|---|---|---|
| | | | |

When will you be having surgery if it is in your budget? ______________________________

**Patient States:** ______________________________

**History of Present Condition:**

Medical Hx

☐ High BP ☐ Heart Disease ☐ Thyroid ☐ Bone Disease
☐ Respiratory Disease ☐ Ear, nose, throat
☐ Arthritis ☐ Cholesterol ☐ TB ☐ Urinary
☐ Stomach ☐ Headache ☐ Skin Disorder
☐ Diabetes ☐ Insulin yrs

**Family (Optometric) Physician Name:**

______________________________

Ocular Hx ☐ Glaucoma ☐ Cataract ☐ __________
Family Hx ☐ Glaucoma ☐ Cataract ☐ __________
Allergies ☐ ______________ ☐ __________
☐ ______________ ☐ Iodine, tape

**Medications** Number: _____ Type/For What? ______________________________

**Contact Lenses:** Rigid _____ Soft _____ Soft Toric _____ Last Worn: MM _____ DD_____ YY_____

| | **OD-Right Eye** Preoperative Examination | **OS-Left Eye** Preoperative Examination |
|---|---|---|
| **Wearing:** | _______+ _______x _______V.A. 20/_______<br>_______ ADD | _______+ _______x _______V.A. 20/_______<br>_______ ADD |
| | How old? _______ | |
| Vision Uncorrected | 20/_______<br>Nearvision: OD J_______ | 20/_______<br>Nearvision: OS J _______ |

Nearvision: OU J_______

**External Exam, Pupils & Mobility** ______________________________

| | OD | OS |
|---|---|---|
| Pupils: | Dim _______ Light _______ (Rosenbuam card) | Dim _______ Light _______ (Rosenbuam card) |
| **Dilation:** | 1/2% M _______ Time_______ Tech Initials _______ | **Dominant:** ☐ OD ☐ OS |
| | OPD I **Topography:** _______<br>☐ Pachymetry _______ | OPD I **Topography:** _______<br>☐ Pachymetry _______ |
| ☐**Manref:**<br>☐**Cycloref:** | _______+ _x_ _V.A. 20/_______ | _______+. _x_ _V.A. 20/_______ |
| T: | A, TP (DR)_______ AP_______ | A, TP (DR)_______ AP_______ |
| Dr. S:<br>☐**Manref:**<br>☐**Cycloref:** | _______+_______x_______V.A. 20/_______ | _______+_______x_______V.A. 20/_______ |
| **SL:** | Clear cornea/lens _______ IOL_______<br>Cat_______KR_______Cap_______ | Clear cornea/lens _______ IOL_______<br>Cat_______KR_______Cap_______ |
| **O:** | C/D ratio 0._______ ☐Normal M/V/P<br>☐No H/T/D ☐No retinal abnormalities | C/D ratio 0. _______ ☐Normal M/V/P<br>☐No H/T/D ☐No retinal abnormalities |

Reversal Drops: Pilocarpine 2% _______
at **Assessment:**

1. ☐ SBK candidate ☐ All Laser LASIK ☐ Epi-Laser ☐ CRI
2. ☐ Dilate day of surgery, ☐ Pressures day of surgery, ☐ Doc repeat refraction
3. ☐ Enter ACT ☐ Enter Datalink
4. ☐ Given Consent Form? ☐ Financial Contract?

**First Post Operative Follow-up Form:** Date:_______________ Age:________

☐ PO Surgery Date: __________OD __________ OS

**O:** ☐ LASIK

| | | **OD-Right Eye** Postoperative Examination | | **OS-Left Eye** Postoperative Examination |
|---|---|---|---|---|
| **Parameter:** | | Flap Position | | |
| ☐ | 0 | In place | 0 | ☐ |
| ☐ | 1 | Slight fluorescein stain at edges | 1 | ☐ |
| ☐ | 2 | < 1 mm gap at edge of keratectomy | 2 | ☐ |
| ☐ | 3 | > 1 mm gap at edge of keratectomy | 3 | ☐ |
| ☐ | 4 | Grossly misaligned flap | 4 | ☐ |
| | | Flap Clarity | | |
| ☐ | 0 | Clear | 0 | ☐ |
| ☐ | 1 | Trace haze | 1 | ☐ |
| ☐ | 2 | Easily visiible haze | 2 | ☐ |
| ☐ | 3 | Confluent haze | 3 | ☐ |
| ☐ | 4 | Opaque flap | 4 | ☐ |
| | | Corneal Clarity | | |
| ☐ | 0 | Clear | 0 | ☐ |
| ☐ | 1 | Trace haze | 1 | ☐ |
| ☐ | 2 | Easily visiible haze | 2 | ☐ |
| ☐ | 3 | Confluent haze | 3 | ☐ |
| ☐ | 4 | Opaque cornea | 4 | ☐ |
| | | Degree of Cells | | |
| ☐ | 0 | No cells | 0 | ☐ |
| ☐ | 1 | Trace cells | 1 | ☐ |
| ☐ | 2 | Easily visiible cells | 2 | ☐ |
| ☐ | 3 | Confluent cells away from Visual axis | 3 | ☐ |
| ☐ | 4 | Confluent cells affecting BCVA or Visual axis | 4 | ☐ |
| | | Degree of Debris | | |
| ☐ | 0 | No debris | 0 | ☐ |
| ☐ | 1 | Trace debris | 1 | ☐ |
| ☐ | 2 | Minimal debris | 2 | ☐ |
| ☐ | 3 | Moderate debris | 3 | ☐ |
| ☐ | 4 | Visually significant debris on visual axis | 4 | ☐ |
| | | Striae | | |
| ☐ | 0 | None | 0 | ☐ |
| ☐ | 1 | One off axis | 1 | ☐ |
| ☐ | 2 | Mulitiple Off axis | 2 | ☐ |
| ☐ | 3 | On axis not visually significant | 3 | ☐ |
| ☐ | 4 | On axis visually significant | 4 | ☐ |
| | ☐ **Surface Epi-Laser** | **Contact Lens removed** ☐ **OD** ☐ **OS** | | |
| ☐ | 0 | Completely healed centrally | 0 | ☐ |
| ☐ | 1 | Trace haze but healed centrally | 1 | ☐ |
| ☐ | 2 | Visible haze with dimple defect | 2 | ☐ |
| ☐ | 3 | Central non-healing with surrounding haze | 3 | ☐ |
| ☐ | 4 | Large non-healing area | 4 | ☐ |

**S:** OD VA SC 20/ ______ OS VA SC 20/ ______

OU VA SC 20/ ______ J.A. OU SC 20/ ______

☐ Optometrist Address: Street:______________________ City:_________________ State:________ Zip:__________

Phone:_______________________________________

☐ Ophthalmologist Address: Street:____________________ City:_________________ State:________ Zip:__________

Phone:

Last Seen:

☐ Letter or ☐ Phone Communication ________Initials

## Laser Vision Calculation and Operative Sheet: (05/22/08) Allegretto Wavelight Laser

**Patient Name:** ______________________ **Age:** ________ **DOB:** ________

☐ **Myopia:** ☐ **Epi-Laser** ☐ **Lasik** **Medical Manager Number:** ________

☐ **Hyperopia:**

| | OD-Right Eye | OS-Left Eye |
|---|---|---|
| **Surgery Date:** | ________ 2008 | ________ 2008 |
| **Dr. Shealy RX** | ____ + ____ x ____ | ____ + ____ x ____ |
| **Minus Myopic RX** | ____ - ____ x ____ | ____ - ____ x ____ axis |

*Spheres greater than 5.75 D---reduce by sphere percent. *Cylinder greater than 1.75---reduce by 25%

| | OD-Right Eye | OS-Left Eye |
|---|---|---|
| **Applied Myopia** | ____ - ____ x ____ | ____ - ____ x ____ **axis** |
| **Pupil Size (dim)** | ( ____ / ____ ) | ( ____ / ____ ) |
| **K readings:** | flat axis ( ____ ) @ ____ /<br>steep axis ( ____ ) @ ____ | flat axis ( ____ ) @ ____ /<br>steep axis ( ____ ) @ ____ |

*Cylinders must be 90 degrees apart

| | OD-Right Eye | OS-Left Eye |
|---|---|---|
| **Dominante Eye** | ☐ OD ☐ OS ________ | ☐ OD ☐ OS ________ |
| **Keratome (Moria)**<br>*use average K's | ☐ O Ring<br>☐ -1 Ring with ____ setting | ☐ O Ring<br>☐ -1 Ring with ____ setting |
| **Pachymetry:** | ( ____ ) residual ____ | ( ____ ) residual ____ |

☐ **Doc, ________ initials Allegretto Applied Nomogram RX:**

☐ **Dave**

| | OD-Right Eye | OS-Left Eye |
|---|---|---|
| **Allegretto** | **Sphere** ____ **Cylinder** ____<br>**Axis** ____ | **Sphere** ____ **Cylinder** ____<br>**Axis** ____ |
| **Aim RX:**<br>+ reverse side | ________ | ________ |

☐ **modified monov.** ☐ **Full monov**

+ reverse side

| | OD-Right Eye | OS-Left Eye |
|---|---|---|
| **Allegretto** | **Sphere** ____ **Cylinder** ____<br>**Axis** ____ | **Sphere** ____ **Cylinder** ____<br>**Axis** ____ |
| **Aim RX:** | ________ | ________ |

☐ **Modified monov.** ☐ **Full monov.**

Eyedrops:
- ☐ Vigamox OU/TID One Week
- ☐ OmniPred OU/TID One Week then BID One Week
- ☐ Zibrom OU/BID 5 Days (2ml)
- ☐ Artificial Tears as necessary

- ☐ Shields
- ☐ Sunglasses per Dr.

Oral
- ☐ PO Tablets Ibuprofen per patient need

**Patient's Name:** ____________ **Date:** ________ **S:** ____________

**Appt X:** ____ **Tech X:** ____ **Dr. X:** ________

**PO** ________ **OV** ____________ **Age:** ________

**OD-Right Eye** | **OS-Left Eye**

**O: SL:**

| OD-Right Eye | OS-Left Eye |
|---|---|
| clear cornea/lens ________ IOL ________ | clear cornea/lens ________ IOL ________ |
| Cat ________ | Cat ________ |
| **RK inc:** ________ **Cap:** ________ | **RK inc:** ________ **Cap:** ________ |
| AP ________ | AP ________ |

**T:**

**M** __ __ **1/2%M** _ __ **Anc: CT VF CS H**

**Manref:** | + ________ x ________ V.A. ________ | ________ + ________ x ________ V.A. ________

**Add:** ________ **T.A. Shealy:** ________

| OD-Right Eye | OS-Left Eye |
|---|---|
| **VA SC 20/** ________ | **VA SC 20/** ________ |
| **J.A. SC** ________ | **J.A. SC** ________ |
| C/D ________ M/V/P ________ H/T/D ________ | C/D ________ M/V/P ________ H/T/D ________ |
| OD ________ | OS ________ |

**I. O.:**

**History:**

| Meds | Med Hx | Ocular Hx | Allgy | Fm Hx |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

A: 1. ________
2. ________
3. ________

P: 1. ________
2. ________
3. ________

**Date:** ________ **Age:** ________ **S:** ____________

**Appt X:** ________ **Tech X:** ________ **Dr. X:** ________

**PO** ________ **OV** ________

**OD-Right Eye** | **OS-Left Eye**

**O: SL:**

| OD-Right Eye | OS-Left Eye |
|---|---|
| clear cornea/lens ________ IOL ________ | clear cornea/lens ________ IOL ________ |
| Cat ________ | Cat ________ |
| **RK inc:** ________ **Cap:** ________ | **RK inc:** ________ **Cap:** ________ |
| AP ________ | AP ________ |

**T:**

**M** __ __ **1/2%M** _ __ **Anc: CT VF CS H**

**Manref:** | + ________ x ________ V.A. | + ________ x ________ V.A. _

**Add:** ________ **T.A. Shealy:** ________

| OD-Right Eye | OS-Left Eye |
|---|---|
| **VA SC 20/** ________ | **VA SC 20/** ________ |
| **J.A. SC** ________ | **J.A. SC** ________ |
| C/D ________ M/V/P ________ H/T/D ________ | C/D ________ M/V/P ________ H/T/D ________ |
| OD ________ | OS ________ |

**I. O.:**

**History:**

| Meds | Med Hx | Ocular Hx | Allgy | Fm Hx |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

A: 1. ________
2. ________
3. ________

P: 1. ________
2. ________
3. ________