COASTAL VISION Medical Group Inc.

Phone (714) 771-1213

Fax (714) 771-7126

☐ **Orange**
293 S. Main St., Ste. 100
Orange, CA 92868

☐ **Irvine**
15825 Laguna Canyon Rd., Ste. 201
Irvine, CA 92618

☐ **Long Beach**
4300 Long Beach Blvd., Ste 400
Long Beach, CA 90807

☐ **Norco**
1524 4th St.
Norco, CA 92860

Pre-Operative Form

Patient Name:_____ **DOB:**_____ **Exam Date:** _____

Ocular History: _____

Contact Lens History: _____ **Discontinued:** _____

Past monovision add in contact lens: _____

Pertinent Medical History: _____ **Allergies:** _____

UCVA (Distance)

OD 20/ _____
OS 20/ _____

Current Best Spectacle Correct VA

OD _____. _____**X**_____**20/**_____
OS _____. _____**X**_____**20/**_____

Monovision: Yes ◯ No ◯
Distance Eye: OD ◯ OS ◯
Target: OD_____**OS**_____

UCVA (Near)
OD J
OS J

IOP: OD_____ **OS** _____
TFBUT/TearLab: OD_____ **OS** _____
Pachymetry: OD_____ **OS** _____

Pupil Size: _____**OD**_____**OS**
Pupil Size: _____**OD**_____**OS**
(Dim Light)

Manifest Refraction

OD _____. _____**X**_____**20/**_____**J**_____

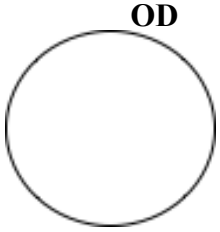
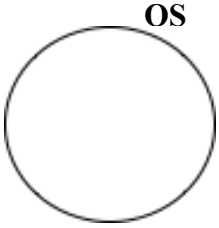
OS _____. _____**X**_____**20/**_____**J**_____

Wet Refraction

OD _____. _____**X**_____**20/**_____

OS _____. _____**X**_____**20/**_____

Slit Lamp Exam

	OD		**OS**
Lids		Lids	
Conjunctiva		Conjunctiva	
Cornea		Cornea	
Anterior Chamber		Anterior Chamber	
Lens		Lens	
Fundus		Fundus	

Assessment/Plan:_____

_____

Referring Doctor: _____ **Fax Number:** _____

Doctor's Signature: _____ **Date:** _____