Patient Name: _____ DOB: _____
Address: _____

Tel: _____

CENTRE FOR SIGHT

Evaluation Form

Date: _____
PC & HPC: _____

POHx: _____

Fam Hx: _____

Eye Meds: _____

Allergies: _____
Contact Lens Hx: SOFT GPCTL PMMA
Last worn: _____
Duration: _____
PMHx: _____

Other Meds: _____

Va

RE	ua		GI	PH
LE	ua		GI	PH

NVa

RE	ua	GI	
LE	ua	GI	

AR

sph	cyl		axis	VA
		x		
		x		

K

	x		
	x		

PG

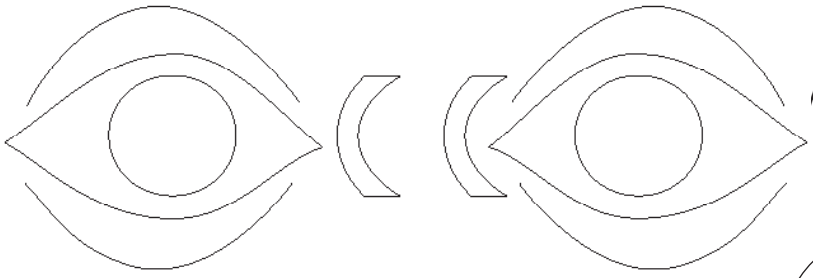
sph	cyl		axis	VA
		x		
		x		

MR

	x		
	x		

PACH: RE _____ LE _____

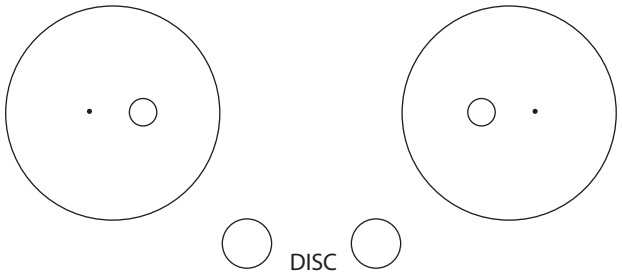
	PUPILS DIM LIGHT	APD?	EOM	ALIGNMENT	LIDS / ADNEXAE
RIGHT					
LEFT					



T RE _____ LE _____

App NCT PEN

DILATED FUNDUS EXAMINATION



LENS:

DX: _____
PLAN: _____

SUITABLE FOR/INTERESTED IN: ☐ LASIK ☐ RLE ☐ CATARACT ☐ PHAKIC ☐ Unsuitable

PATIENT COUNSELLED ☐ YES
BROCHURE GIVEN ☐ YES
CENTRE CONTACTED ☐ YES

Signature: _____

Name: _____