Patient _____ DOB: _____
Ad- _____
_____
_____
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
RE	ua	GI	
LE	ua	GI	

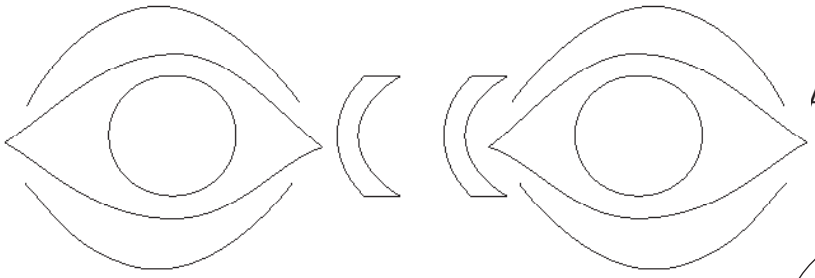
sph	cyl		axis	VA
		x		
		x		
		x		
		x		

K

sph		axis
	x	
	x	
	x	
	x	

	RE	LE
PACH:		

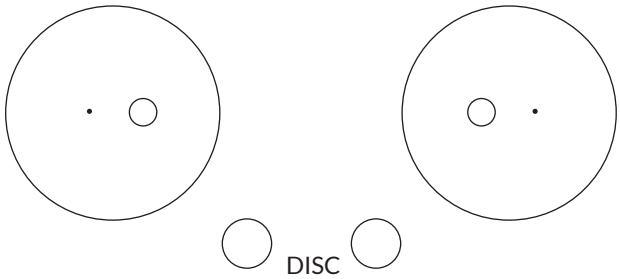
	PUPILS DIM LIGHT	APD?	EOM	ALIGNMENT	LIDS / ADNEXAE
RIGHT					
LEFT					



T RE _____
LE _____

App NCT PEN

DILATED FUNDUS EXAMINATION



LENS:

DX:
PLAN: _____

SUITABLE FOR/INTERESTED ☐ LASIK ☐ RLE ☐ CATARACT ☐ PHAKIC ☐ Unsuitable
PATIENT COUN- ☐ YES
BROCHURE GIVEN ☐ YES
CENTRE CONTACT- ☐ YES

Signature: _____

Name: _____