



Kelowna Laser Vision inc.

Patient _____ DOB _____ Date of Exam _____

Pts. Address _____ Telephone _____

Medical History _____

Medications _____

Ocular History _____

Contact Lens History _____

Uncorrected OD 20/ _____ OS 20/ _____

Current Glasses OD _____ x _____ 20/ _____ OS _____ x _____ 20/ _____

Subj. Refraction OD _____ x _____ 20/ _____ OS _____ x _____ 20/ _____

Cycloplegic (as needed) OD _____ x _____ 20/ _____ OS _____ x _____ 20/ _____

Keratometry OD _____ @ _____ x _____ OS _____ @ _____ x _____

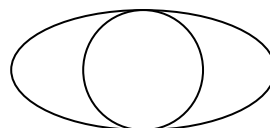
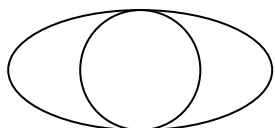
IOP OD _____ OS _____

Binocularity Normal Abnormal: Reason _____

Mono vision Not discussed Discussed (if patient is over 40 years old)

Dominant Eye OD OS

Anterior Segment / Slit Lamp



- Cornea clear
- Lens clear
- Abnormal changes _____

- Fundus Exam Dilated (LASIK) Non-Dilated
- Normal
 - Abnormal changes _____

Dr.'s Comments _____

Referring Doctor _____ Address _____

Phone _____ Fax _____