HERZIG
EYE INSTITUTE

CONSULTATION FORM

P (416) 929-2020
F (416) 929-0232

Patient Name: ______________________ **Date of Birth:** ______________________
(MM / DD / YYYY) Age

Address: ______________________

Phone Number: Home ( ) ______________________ **Work** ( ) ______________________

Cell ( ) ______________________

Email Address: ______________________

(Please complete all requested information)

Date of Examination: ______________________ *(MM/DD/YYYY)*

Patient wearing CL today? ☐ *Yes* ☐ *No* *If no, date last worn:* ______________________ *(MM/DD/YYYY)*

CL Type: ☐ *Soft* ☐ *Hard* ☐ *Rigid Gas Permeable* **CL Power:** *OD:* ________ *OS:* ________

Medical History/Allergies: ______________________

UCVA

OD: 20/

OS: 20/

Present Correction (Age of Rx: ______)

OD: ______ ______ X ______ 20/

OS: ______ ______ X ______ 20/

Keratometry:

OD: ______ @ ______ *OS:* ______ @ ______

______ @ ______ ______ @ ______

Manifest:

OD: ______ ______ *X* ______ *20/*

OS: ______ ______ *X* ______ *20/*

sphere *cylinder* axis

Cycloplegic:

OD: ______ ______ *X* ______ *20/*

OS: ______ ______ *X* ______ *20/*

sphere *cylinder* axis

Pupil Size:

OD: ______ / ______

OS: ______ / ______

Bright *Dim*

Dominant Eye:

OD *OS*

(Circle one)

Corneal Thickness
(if available)

OD: ______

OS: ______

IOP:

OD: ______

OS: ______

Monovision Discussed*:* ☐ *Yes* ☐ *No* **Comments***:* ______________________

Slit Lamp Examination*:* *OD* *OS*

Fundus *Fundus*

Referring Doctor / Optometrist: ______________________

Address: ______________________

Phone #: ______________ **Fax #:** ______________

Email: ______________________

Meeting Date: ______________________

Tx Date: ______________________

Comments: ______________________

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