HERZIG EYE INSTITUTE

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CONSULTATION FORM

☐ Dr. Herzig ☐ Dr. Eplett
☐ Dr. Taylor ☐ Dr. Ma

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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