HERZIG
EYE INSTITUTE

Consultation Form

PH: 416-929-2020
Fax: 416-929-0232

Patient Name:		DOB:	Age:
Address:		City:	Postal:
Home Phone:		Cell Phone:	
Email:			
HC:	VC:	Gender:	

Medical Hx / Allergies: ____

Exam Date: ______________________

Wearing CL today? Yes **Type:** Soft Hard RGP **Date Last Worn:** ____________

UCVA
OD 20/
OS 20/

Present Correction **(Age of Rx: _________)**
OD _______ _______ X ____ 20/
OS _______ _______ X ____ 20/

Dominant Eye
OD
OS

Manifest Refraction
OD _____ _____ X _____ 20/
OS _____ _____ X _____ 20/

Cycloplegic Refraction
OD _____ _____ X _____ 20/
OS _____ _____ X _____ 20/

Pupil Size
OD ______ / ______
OS ______ / ______
Bright Dim

Corneal Thickness
OD ___________
OS ___________

IOP
OD ______
OS ______

Monovision Discussed: YES NO **Comments:** ______________________________

Slit Lam Examination:

OD

OS

Fundus:

Fundus:

Referring Doctor:		Billing Number:
Address:		Meeting Date:
Phone:	Fax:	Surgery Date:
Email:		Comments: