

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

Medical Hx / Allergies: _____

Current dry eye therapy: _____

Exam Date: _____

Present Correction

OD _____ X _____ 20/

OS _____ X _____ 20/

IOP

OD _____

OS _____

Contact Lens Wear:

None Hard

Soft RGP

Slit Lamp Exam

OD

OS

Fundus Exam

OD

OS

Comments:

Patient Interested in: LipiFlow Yes No Microblepharoexfoliation Yes No

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