

REAL Vision[®] Doctor's Examination Form

NAME: _____ EXAM DATE: _____

DOB: _____ AGE: _____ M F Consult w/ _____ Seminar

Procedure Recommended: _____ Co-Manage: No Yes Dr. _____

Occupation/ Vision Needs/ Goals: _____

Meds: _____ PMH: _____ OcHx: _____

FHx: _____ Allergies: _____ Other: _____

Other: _____

PRESENT SYSTEMS: Spectacles SCL RGP Reading glasses Monovision

UNAIDED VA 20/20 UNAIDED VA NEAR 20/20 DOMINANT EYE: R L

ORBSCAN DONE OU
WAVESCAN DONE OU

PUPILSCAN OD _____
OS _____

ACCOM. AMPLITUDE _____

BC BINOCULAR DISTANCE 20/ _____
BC BINOCULAR NEAR 20/ _____
BC BINO NEAR THRU DISTANCE MANIFEST 20/ _____

TONOMETRY

OD _____ mmHg Tonopen
OS _____ mmHg Goldmann

KERATOMETRY

OD _____ @ _____
OS _____ @ _____

CURRENT RX	ADD	
OD	20/	20/
OS	20/	20/
MANIFEST REFRACTION	ADD	
OD	20/	20/
OS	20/	20/
DILATED: MYD 0.5% MYD 1% Time _____		
CYCLOPLEGIC REFRACTION		
OD	20/	20/
OS	20/	20/
SLIT LAMP EXAM: Within normal limits		FUNDUS EXAM:

Diagnosis: _____

Issues Discussed: _____

GOAL: OD _____ OS _____ PROCEDURE: _____

Exam by: _____ Doctor: _____

Next visit: _____