ALOHA LASER VISION
People Of Vision

HISTORY AND PHYSICAL FORM

Patient Name: _____ **DOB:** _____

Surgery Date: _____ Surgeon: ❑ Alan R. Faulkner, MD

Type of Surgery:
- ❑ Refractive Lens Exchange
- ❑ Cataract Surgery
- ❑ Pterygium Surgery
- ❑ Visian ICL Surgery
- ❑ Blepharoplasty
- ❑ Other: _____

Indication for Surgery:
- ❑ Poor vision
- ❑ Glare
- ❑ Obstructed vision
- ❑ Discomfort
- ❑ Desire to be free of glasses
- ❑ Other: _____

- COMPLETED FORM MUST HAVE EXAM DATE WITHIN 30 DAYS OF SURGERY
- Surgery will be performed under topical anesthesia & MAC
- Lab work is not required for local, standby, or topical cases; EKG as medically indicated.

Exam Date: _____

BP: _____ / _____ Pulse: _____ Resp: _____ HT: _____ WT: _____

Allergies: _____

Medical / Surgical History: _____

Medications: _____

HEENT: _____

Heart: _____

Lungs: _____

Abdomen: _____

Extremities: _____

Impression: _____

>> Is the patient cleared for AMBULATORY surgery? (circle one) YES / NO

Is the patient on any medication or treatment that should not be stopped for surgery? _____

Additional comments: _____

Doctor's Signature: _____ Date: _____

Print Doctor's Name: _____ Doctor's office phone #: _____

PLEASE FAX THE COMPLETED FORM TO **ALOHA LASER VISION AT **808-599-4818****

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