



**Rental Services
Patient Information Sheet**

Patient Name: _____ **Initial Exam** _____
Last First **Follow Up** _____

D.O.B. ____/____/____

Corneal Condition:

Clear ____ Opacity (describe) _____

Cataract: OD ____ OS ____

Dilated: Yes ____ No ____

Current Manifest:

	OD	OS
Sphere	_____	_____
Cylinder	_____	_____
Axis	_____	_____

Test Type:

Glaucoma ____

Retina ____

Other Comments (e.g., patient has special needs which are not obvious such as Alzheimer's, hearing problems etc.):