We appreciate your interest in seeking us for your vision corrective surgery and request you or your eye surgeon/doctor to fill these basic details regarding your eyes so we can review prior to your personal teleconference with Dr. Gulani.

Patient Name: **Date of Birth:**

Your Eye Doctor's Name: **Phone:** **Email:**

VA (Vision): (OD): Sc:
Cc:

(OS): Sc:
Cc:

Manifest Refraction:
(OD): , x :20/
(OS): , x :20/

Glasses Prescription:
(OD): , x :20/
(OS): , x :20/

Contact Lens Prescription (Type of contact lenses: Soft/RGP/Scleral)**:**
(OD): , x :20/
(OS): , x :20/

Eye Exam Note to Include:
Status of your Cornea and Natural Lens:
Status of your Retina (if any retinal problems):
Stability of Glaucoma (if history of glaucoma):
History of eye surgeries with dates and surgeon names if possible:
Basic Tests: Corneal Topography/ Slit Lamp Image-photo / Cl Trial (in corneal scar cases):

We at Gulani Vision Institute will conduct our own advanced diagnostics given the level of Dr. Gulani's assessment in his personal consultation but the above information will allow us to prepare for you accordingly before you travel to us.

Tele: 904-296-7393 Fax: 888-397-4699 Email: gulanivision@gulani.com