



# Argonne Medical Department Laser Eye Examination Form

**Part A:** Laser user contact information and brief medical history – to be completed by laser user

Name: \_\_\_\_\_ Badge # \_\_\_\_\_ Date: \_\_\_\_\_

Usual/permanent address \_\_\_\_\_

Usual/permanent phone# \_\_\_\_\_ e-mail \_\_\_\_\_

Argonne address \_\_\_\_\_ Argonne extension \_\_\_\_\_

Argonne supervisor/sponsor \_\_\_\_\_ Argonne extension \_\_\_\_\_

If at ANL temporarily – Arrival date \_\_\_\_\_ Departure date \_\_\_\_\_

What type of lasers will you be working with or near?

UV  visible  IR  other (specify) \_\_\_\_\_

**Brief medical history:**

Please list current medications: \_\_\_\_\_

Do you have any of the following conditions?

Aphakia (absence of a lens in one or both eyes)

Photosensitivity (unusual sensitivity of the skin or eyes to sunlight or other light)

Please describe if you checked either of the above:

Laser user signature: \_\_\_\_\_

**Instructions to laser user:** After completing Part A, give the entire form, including instructions, Part A and Part B, to the examining ophthalmologist.



# Argonne Medical Department Laser Eye Examination Form

## Part B: To be completed by ophthalmologist

Examinee name \_\_\_\_\_ Date of exam \_\_\_\_\_

Current complaints \_\_\_\_\_

Ocular history \_\_\_\_\_

Pertinent family history \_\_\_\_\_

### Ocular examination

Visual acuity

Far point

	Uncorrected	Corrected
OD		
OS		

Near Point

	Uncorrected	Corrected
OD		
OS		

Refraction: \_\_\_\_\_

Macular function (by Amsler grid or other pattern): \_\_\_\_\_

Visual fields: \_\_\_\_\_

Color vision: \_\_\_\_\_

Intraocular pressure (if over age 40 or otherwise indicated): OS \_\_\_\_\_ OD \_\_\_\_\_

Pupils and motility: \_\_\_\_\_

Anterior segment: \_\_\_\_\_

Fundus: \_\_\_\_\_

Impression:  Normal  
 Abnormal \_\_\_\_\_

### Examiner Information

Ophthalmologist name and title: \_\_\_\_\_

Signature: \_\_\_\_\_ Medical license#/state: \_\_\_\_\_

Office address: \_\_\_\_\_ Phone #: \_\_\_\_\_

- Argonne employee: Please send/bring parts A & B to the Argonne Medical Dept, 9700 S. Cass Ave, Building 201, Argonne, IL 60439 or Fax to 630-252-6615 to receive your certification - If questions call 630-252-2811.