San Francisco State University
Laser Program

Eye Exam for Laser Users

The SFSU campus Laser Safety Plan requires personnel, who work with Class 3b and Class 4 laser systems, to have a baseline ocular examination. This requirement is consistent with the recommendations in ANSI Z136.5-2000, "Safe Use of Lasers in Educational Institutions". The purpose of these eye exams is to establish a baseline in the event of an accidental injury and to identify certain workers who might be at special risk.

Section 1: Patient Information

Name _____ _____
First MI Last SFSU ID

Address _____
Street City State ZIP

Details _____ _____
Local Telephone No. Date of Birth ❒ Female ❒ Male

Relation or friend to notify in case of an emergency _____ _____
Name Contact No.

1. Do you require corrective vision? ❒ NO ❒ YES Age of current glasses _____ contacts _____

   Do you wear glasses? ❒ NO ❒ YES Worn: ❒ Always ❒ Distance Only ❒ Reading Only
   Do you wear contacts? ❒ NO ❒ YES Average wearing time per day? _____

2. Reason for exam: ❒ Pre-Placement Exam ❒ Post-Incident Exam ❒ Exit Exam

Section 2: Medical History

Examination Date

Chief Complaint _____ _____
(if any) Date of Last Eye Exam

Personal Health History

Have you had any problems with your eyes in the past? ❒ NO ❒ YES When?
_____ _____
_____ _____

Have you had any of the following serious illnesses?
❒ Cancer ❒ Diabetes ❒ High Blood Pressure ❒ Heart Disease
❒ Glaucoma ❒ Cataracts ❒ Other eye-related diseases _____

Are you currently under medical care for any chronic or long-term illnesses? ❒NO ❒YES
_____ / Medication _____
_____ / Medication _____

Medications

Do you smoke now? ❒ NO ❒ YES _____
Are you taking any medications/supplements? ❒ NO ❒ YES _____

Allergies

Are you allergic to any medications? ❒ NO ❒ YES _____
Other allergies? ❒ NO ❒ YES _____

Family History

Have any of your (close) blood relatives had any of the following serious illnesses?
❒ Cancer ❒ Diabetes ❒ High Blood Pressure ❒ Heart Disease
❒ Glaucoma ❒ Cataracts ❒ Other eye-related diseases _____

Section 3: Required Procedures

1. Visual Acuity ❒ WITH / ❒ WITHOUT Eye Glasses or Contact Lenses

Distance	OD 20 / _____	OS 20 / _____
Near	OD 20 / _____	OS 20 / _____
Current eye glasses	OD _____	OS _____

2. Macular Function *(Amsler Grid)*

OD NORMAL / ABNORMAL _____

OS NORMAL / ABNORMAL _____

3. Color Vision

Method D-15 100 Hue other *(circle one)*

Result OD NORMAL / ABNORMAL _____

OS NORMAL / ABNORMAL _____

4. Fundoscopy *(with pupil dilation)*

Optic Nerve	OD _____	OS _____
Maculae	OD _____	OS _____
Periphery	OD _____	OS _____

5. Summary

Binocular Vision _____

Anterior Segment Anomalies _____

Please list cause, if applicable:

Vision decrease _____

Amsler Grid anomaly: _____

Color Vision defect: _____

Any other anomalies noted _____

Assessment/Additional Notes: _____

_____

_____

❒ At this time, additional testing for suitability to work with high-powered lasers is not indicated.

❒ I recommend additional testing to adequately assess a special risk or particular eye condition.

❒ Contrast Sensitivity Testing **❒ Macular Photostress** **❒ Retinal Photography**

_____ ❒ OD ❒ MD

Printed Name or Examining Eye Care Professional

_____

Signature

_____ /_____ /_____

Date

If any of the baseline tests show an abnormal ocular function that could be affected by work with lasers, the examining eye care professional may order supplemental testing to ensure an adequate eye health assessment. Please note that these tests will need to be performed off-campus, as the SFSU Student Health Services center does not have the necessary equipment.

Section 4: Supplemental Eye Exam for Laser Users

Patient Name: _____ (please print)
First MI Last

Standard Baseline Eye Exam, given on this date _____, is attached ❒ YES ❒ NO

Location Performed: ❒ SFSU Student Health Center ❒ _____
❒ UC Berkeley Eye Center

a. Contrast Sensitivity Testing

Method _____

Result OD _____

OS _____

b. Macular Photostress

(in seconds to recover 1 line above max V.A.)

Method _____

Result OD _____

OS _____

c. Retinal Photographs

❒ 35 mm ❒ Polaroid ❒ Other _____

Notes: _____

_____

Summary/Notes/Recommendations _____

_____

_____

_____

_____ ❒ OD ❒ MD _____
Examining Eye Care Professional Signature Date

Location Performed: ❒ UC Berkeley Eye Center ❒ _____