

Post-operative Evaluation

Exam Date _____
 Month: 1 3 6 12 Other: _____
 Doctor Name: _____
 Office Contact: _____
 Office Phone: _____
 Original Procedure Date: _____
 Enh. Procedure Date: _____

Comanagement Fees Received: Yes No
 Patient Name: _____
 Phone (H): _____
 Phone Day: _____
 Birthdate: _____ Age: _____
 Gender: Male Female
 LASIK PRK CXL

Pre-Procedure RX

	SPHERE	CYL.	AXIS	BCVA		SPHERE	CYL.	AXIS	BCVA
OD				20/	OS				20/

UCVA OD 20/ OS 20/ Patient Comments: _____

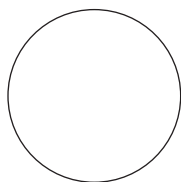
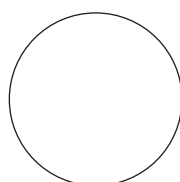
Subjective Refraction

	SPHERE	CYL.	AXIS			SPHERE	CYL.	AXIS	
OD				20/	OS				20/

Cycloplegic Refraction (At the 3 month post-operative exam if vision is not satisfactory or if enhancement is considered.)

	SPHERE	CYL.	AXIS			SPHERE	CYL.	AXIS	
OD				20/	OS				20/

Slit Lamp Exam

OD		I.O.P.		OS
		Clear		
		Haze		
		Debris		
		Ingrowth		

Meds Tobradex Artificial Tears Other _____

Doctor Comments: _____

Requesting Enhancement: Yes No _____

For Office Use:	Recommended Procedure: _____	Notified Patient: _____	Notified OD: _____
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