LASIK MD VISION

POST-OPERATIVE EVALUATION

Patient Name: DOB (month/day/year):

Practicing Optometrist Name: Clinic Address:

Exam Date (month/day/year): MONO Undercorrection: ☐ OD ☐ OS

Post-operative exam : ☐ 1 day ☐ 7 days ☐ 1 month ☐ 3-6 months ☐ 1 year ☐ Other _____

	OD	OS
Surgery Date		
Procedure Type ☐ Initial ☐ ENH	☐ LASIK ☐ PRK ☐ ACW ☐ AWO ☐ FEMTO ☐ CXL	☐ LASIK ☐ PRK ☐ ACW ☐ AWO ☐ FEMTO ☐ CXL
Comfort	☐ Good ☐ Discomfort ☐ Dryness	☐ Good ☐ Discomfort ☐ Dryness
Medications	☐ None _____ ☐ Tears _____ ☐ Pred Forte _____ ☐ Maxidex _____ ☐ Zymar _____ ☐ Other _____	☐ None _____ ☐ Tears _____ ☐ Pred Forte _____ ☐ Maxidex _____ ☐ Zymar _____ ☐ Other _____
UCVA	☐ Good ☐ Blurry ☐ Night Glare 20/ _____	20/ _____ ☐ Good ☐ Blurry ☐ Night Glare 20/ _____
Refraction	20/ _____	20/ _____
	☐ Normal ☐ Particles ☐ DLK ☐ 1 ☐ 2 ☐ 3 ☐ Striae ☐ PEE ☐ 1 ☐ 2 ☐ 3 ☐ EI Max _____ mm ☐ Other _____	☐ Normal ☐ Particles ☐ DLK ☐ 1 ☐ 2 ☐ 3 ☐ Striae ☐ PEE ☐ 1 ☐ 2 ☐ 3 ☐ EI Max _____ mm ☐ Other _____
Next Visit _____ ☐ Days ☐ Weeks ☐ Months ☐ First CHE	I would like to refer this patient back to LASIK MD for: ☐ A review for enhancement ☐ An appointment Plan / Notes : Monitor : ☐ Happy ☐ Not Happy Next Appointment: ☐ TOPOS ☐ AR IOP OD _____ OS _____	

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