

LASIK/PRK POST-OP FORM

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Fax: (866)-351-9920

☐ LASIK ☐ OU ☐ OD ☐ OS
☐ PRK ☐ OU ☐ OD ☐ OS

PATIENT: _____ DOB: ____/____/____ AGE: _____

AFFILIATE: _____ PHONE: _____ FAX: _____

OD

PROCEDURE DATE: ____/____/____ TARGET: DISTANCE / MONO

PROCEDURE TYPE: INITIAL / ENHANCEMENT

POST-OP DATE: ____/____/____

DAY ____ WEEK ____ MONTH ____ (FROM SURGERY)

PATIENT COMMENTS: _____

MEDS: _____

UCVA: 20/ ____ MANIFEST (WET / DRY) _____ 20/ ____

REFRACTION (1 MO. & 3 MO.)

_____ **20/** _____

BIOMICROSCOPY

ADNEXIA: NORMAL / OTHER

CONJUCTIVA: NORMAL / OTHER

TEAR FILM: NORMAL / DRY

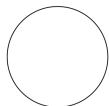
IOP: _____ ④

FLAP EVALUATION

POSITION: EXCELLENT / DECENTERED

CLARITY: CLEAR / EDEMA / HAZE

EDGES: SMOOTH / ROLLED



SUMMARY: EXCELLENT / STABLE / REFER TO DR. HU / OTHER

TREATMENT / FOLLOWUP / COMMENTS: _____

OS

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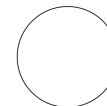
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TREATMENT / FOLLOWUP / COMMENTS: _____

AFFILIATE SIGNATURE: _____

DATE: ____/____/____