Eye Doctors OF WASHINGTON

SURGERY-FOLLOW-UP INFORMATION

PATIENT: _____

AGE:_____ Date: / /

Eye Care Provider_____ Phone: _____Fax:_____Email:_____

CHIEF COMPLAINT: _____

_____

_

VISIT #: (from date of initial surgery)

OD: 1 day 1–2 wks 1–2 mo 3-6 mo 12 mo _____

OS: 1 day 1–2 wks 1–2 mo 3-6 mo 12 mo _____

INITIAL SURGERY:

OD: Date: _____ CV LASIK STD LASIK ____ PRK _____

OS: Date: _____ CV LASIK STD LASIK ____ PRK _____

INTRALASE MICROKERATOME

DISTANCE OU MONOVISION_____

ADDITIONAL SURGERY (ENHANCEMENTS):

OD: Date: _____ CV LASIK STD LASIK ____ PRK _____

OD: Date: _____ CV LASIK STD LASIK ____ PRK _____

OS: Date: _____ CV LASIK STD LASIK ____ PRK _____

OS: Date: _____ CV LASIK STD LASIK ____ PRK _____

SUBJECTIVE

	Glare R L	Halos R L	Diplopia R L		Day R L	Night R L
None				Excellent		
Trace				Very Good		
Mild				Good		
Moderate				Fair		
Severe				Poor		

UNCORRECTED VISION

Distance: OD: 20/ ____ CF OS: 20/ ____ CF

Near: OD: 20/ ____ CF OS: 20/ ____ CF

POSTOPERATIVE REFRACTION

Manifest (1-2 week & 1-2 month visits or before enhancement)

OD:____ ____.____ ____ ____ ____.____ ____ ___ ___ ___ 20/_____

Sphere Cylinder Axis

OS:____ ____.____ ____ ____ ____.____ ____ ___ ___ ___ 20/_____

Sphere Cylinder Axis

Cycloplegic (before enhancement)

OD:____ ____.____ ____ ____ ____.____ ____ ___ ___ ___ 20/_____

Sphere Cylinder Axis

OS:____ ____.____ ____ ____ ____.____ ____ ___ ___ ___ 20/_____

Sphere Cylinder Axis

IOP

(no measurements until 4 weeks after surgery)

OD: _____ mm Hg OS: _____m Hg

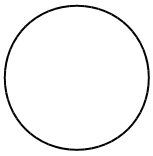
Keratometry

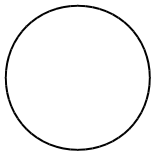
OD: _____/ _____ _____ OS:_____/ _____ _____

Steep Flat Axis Steep Flat Axis

SLIT-LAMP EXAMINATION

Epithelium:			
OD:	0- Intact 1- SPK 2- Small Epi. Defect 3- Large Epi. Defect	OS:	0- Intact 1- SPK 2- Small Epi. Defect 3- Large Epi. Defect
Stroma:			
(Haze) OD:	0- Clear 1- Minimal 2- Mild 3- Moderate 4- Severe	OS:	0- Clear 1- Minimal 2- Mild 3- Moderate 4- Severe
Flap:			
(Folds) OD:	0- None 1- Trace 2- Mild 3- Moderate 4- Severe	OS:	0- None 1- Trace 2- Mild 3- Moderate 4- Severe
Interface:			
(Debris)OD:	0- None 1- Trace 2- Mild 3- Moderate 4- Severe	OS:	0- None 1- Trace 2- Mild 3- Mod 4- Severe





Medicines:

Assessment:

Plan:

Signature:_____

Notes:

Please fax completed form Attn: Refractive Coordinator, 240-482-1220.

Revised 2007