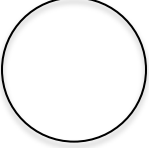
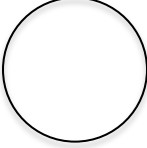
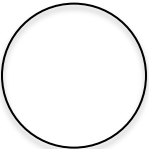
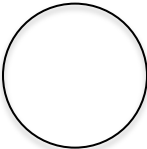
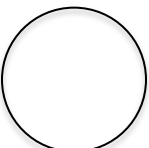
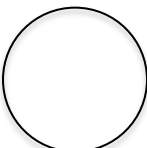


Patient:	Age:	Eye Care Provider:
<u>Surgical Information:</u>		Notes:
<u>OD</u>	<u>OS</u>	
MR:	MR:	
CR:	CR:	
Surgery: LASIK PRK MONO	Surgery: LASIK PRK MONO	
Enhancements:	Enhancements:	
1) Date:	1) Date:	
2) Date:	2) Date:	

Date: Visit: POD ___ / POW ___ / POM ___ / POY ___ Chief Complaint: _____ <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <u>OD</u> UCVA: Dist 20/ Near 20/ MR: _____ CR: _____ </div> <div style="text-align: center;"> <u>OS</u> UCVA: Dist 20/ Near 20/ MR: _____ CR: _____ </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div style="text-align: center;">  Assessment: </div> <div style="text-align: center;">  Plan: </div> </div> <div style="margin-top: 10px;"> <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;"> <table style="width:100%; border: none;"> <tr> <td style="border: none;">_____ Epi _____</td> <td style="border: none;">_____ Ta _____</td> </tr> <tr> <td style="border: none;">_____ Strom _____</td> <td style="border: none;">_____ OS _____</td> </tr> <tr> <td style="border: none;">_____ Flap _____</td> <td style="border: none;">_____ Time: _____</td> </tr> <tr> <td style="border: none;">_____ Inta _____</td> <td style="border: none;">_____ OD _____</td> </tr> </table> </td> <td style="width:50%; border: none; vertical-align: top;"> Tech: Medication History: OD/OS <input type="checkbox"/> Bes/Zym ___/___ → ___/___ <input type="checkbox"/> PF/ Lot ___/___ → ___/___ <input type="checkbox"/> Brom ___/___ → ___/___ <input type="checkbox"/> Tears _____ ___/___ → ___/___ <input type="checkbox"/> Restasis ___/___ → ___/___ <input type="checkbox"/> Comfort Drops _____ ___/___ → ___/___ </td> </tr> </table> </div>	<table style="width:100%; border: none;"> <tr> <td style="border: none;">_____ Epi _____</td> <td style="border: none;">_____ Ta _____</td> </tr> <tr> <td style="border: none;">_____ Strom _____</td> <td style="border: none;">_____ OS _____</td> </tr> <tr> <td style="border: none;">_____ Flap _____</td> <td style="border: none;">_____ Time: _____</td> </tr> <tr> <td style="border: none;">_____ Inta _____</td> <td style="border: none;">_____ OD _____</td> </tr> </table>	_____ Epi _____	_____ Ta _____	_____ Strom _____	_____ OS _____	_____ Flap _____	_____ Time: _____	_____ Inta _____	_____ OD _____	Tech: Medication History: OD/OS <input type="checkbox"/> Bes/Zym ___/___ → ___/___ <input type="checkbox"/> PF/ Lot ___/___ → ___/___ <input type="checkbox"/> Brom ___/___ → ___/___ <input type="checkbox"/> Tears _____ ___/___ → ___/___ <input type="checkbox"/> Restasis ___/___ → ___/___ <input type="checkbox"/> Comfort Drops _____ ___/___ → ___/___
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Date: Visit: POD ___ / POW ___ / POM ___ / POY ___ Chief Complaint: _____ <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <u>OD</u> UCVA: Dist 20/ Near 20/ MR: _____ CR: _____ </div> <div style="text-align: center;"> <u>OS</u> UCVA: Dist 20/ Near 20/ MR: _____ CR: _____ </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 10px;"> <div style="text-align: center;">  Assessment: </div> <div style="text-align: center;">  Plan: </div> </div> <div style="margin-top: 10px;"> <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;"> <table style="width:100%; border: none;"> <tr> <td style="border: none;">_____ Epi _____</td> <td style="border: none;">_____ Ta _____</td> </tr> <tr> <td style="border: none;">_____ Strom _____</td> <td style="border: none;">_____ OS _____</td> </tr> <tr> <td style="border: none;">_____ Flap _____</td> <td style="border: none;">_____ Time: _____</td> </tr> <tr> <td style="border: none;">_____ Inta _____</td> <td style="border: none;">_____ OD _____</td> </tr> </table> </td> <td style="width:50%; border: none; vertical-align: top;"> Tech: Medication History: OD/OS <input type="checkbox"/> Bes/Zym ___/___ → ___/___ <input type="checkbox"/> PF/ Lot ___/___ → ___/___ <input type="checkbox"/> Brom ___/___ → ___/___ <input type="checkbox"/> Tears _____ ___/___ → ___/___ <input type="checkbox"/> Restasis ___/___ → ___/___ <input type="checkbox"/> Comfort Drops _____ ___/___ → ___/___ </td> </tr> </table> </div>	<table style="width:100%; border: none;"> <tr> <td style="border: none;">_____ Epi _____</td> <td style="border: none;">_____ Ta _____</td> </tr> <tr> <td style="border: none;">_____ Strom _____</td> <td style="border: none;">_____ OS _____</td> </tr> <tr> <td style="border: none;">_____ Flap _____</td> <td style="border: none;">_____ Time: _____</td> </tr> <tr> <td style="border: none;">_____ Inta _____</td> <td style="border: none;">_____ OD _____</td> </tr> </table>	_____ Epi _____	_____ Ta _____	_____ Strom _____	_____ OS _____	_____ Flap _____	_____ Time: _____	_____ Inta _____	_____ OD _____	Tech: Medication History: OD/OS <input type="checkbox"/> Bes/Zym ___/___ → ___/___ <input type="checkbox"/> PF/ Lot ___/___ → ___/___ <input type="checkbox"/> Brom ___/___ → ___/___ <input type="checkbox"/> Tears _____ ___/___ → ___/___ <input type="checkbox"/> Restasis ___/___ → ___/___ <input type="checkbox"/> Comfort Drops _____ ___/___ → ___/___
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