

Post Operative Evaluation Form

Patient Name: _____ **Date:** _____

Surgery Date: OD _____/_____/_____ OS _____/_____/_____

Procedure Performed: Conventional LASIK Custom LASIK PRK RK AK LTK
Enhancement Other _____

* **If enhancement**, original surgery dates: OD _____/_____/_____ OS _____/_____/_____

PATIENT HISTORY:

Current Medications: OD _____ OS _____

UCVA **PH** **J**
OD 20/____ 20/____ _____

Patient Satisfaction
1 2 3 4 5

OS 20/____ 20/____ _____
REFRACTION

1 2 3 4 5
CYCLOPLEGIC

OD _____ - _____ x _____

OS _____ - _____ x _____

Flat Steep Steep Axis

K Readings OD _____/_____ x _____

IOP Goldman/NCT

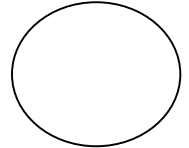
OS _____/_____ x _____

OD _____ OS _____

LASIK Cap

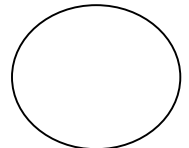
OD

Position: Normal Dislodged Decentered
Clarity: Normal Folds Haze
Interface: Normal Opacities Epithelial Ingrowth
Edges: Normal Rolled Erode



OS

Position: Normal Dislodged Decentered
Clarity: Normal Folds Haze
Interface: Normal Opacities Epithelial Ingrowth
Edges: Normal Rolled Erode



PRK

OD: BCL: In Place Decentered Absent Removed Defect: _____MM
OS: BCL: In Place Decentered Absent Removed Defect: _____MM
Haze: OD None 1 2 3 4
OS None 1 2 3 4

RK/AK

Incisions Healed: OD: Yes No OS: Yes No

LTK

Epithelium Intact: OD: Yes No OS: Yes No

Current Plan:

Doctor Signature: _____ Next Appointment: _____