Date of Exam_____________ Post Op Number 1 day 1 week 1 month 3 month 6 month __________

Patient Information:	Name		Date of Surgery
Patient Comments:			
Ocular Medications:			
Target Refraction	DV ____________ NV ____________		DV ____________ NV ____________
Total Visual Acuity	Distance with both eyes open 20/________		Near with both eyes open 20/________
Post op Assessment	OD		OS
Uncorrected Visual Acuity	Distance 20/ Near 20/		Distance 20/ Near 20/
Manifest Refraction	20/		20/
Cycloplegic Refraction Dilated@_______ Myd/Neo/Cyclo	20/		20/
Keratometry	Steep K @ Flat K @		Steep K @ Flat K @
Slit Lamp Exam: Grade according to the following scale: 0 = none/normal 1 = Trace, 2=mild, 3 = moderate, 4 = severe IOP OD________ OS ________		___Epithelial Defect___ ___Epithelial Stain___ ___Stromal Edema___ ___Flap Wrinkling ___ ___Flap Edema ___ Flap Interface ___ Debris ___ Flap Interface ___Epithelium ___ ___Lens ___ ___AC ___	
Return Visit	Comments Plan		
Co-Managing Doctor	Phone:	Fax:	
	Date: M______/D______/Y______		

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