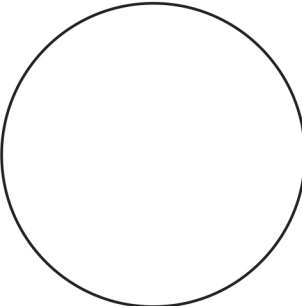
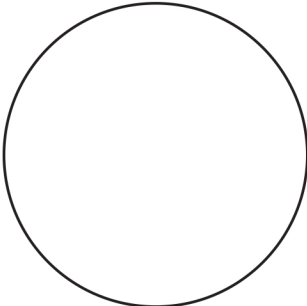




Date of Exam \_\_\_\_\_ Post Op Number 1 day 1 week 1 month 3 month 6 month \_\_\_\_\_

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_____	