

Post-Procedure LASIK Evaluation

Patient Name: _____

3900 Essex Lane Suite 101, Houston, TX 77027
 Phone 713-626-5544 Fax 713-626-7744

Comanaging

Doctor _____

Contact _____

-

RIGHT EYE

Procedure Date _____

Procedure Type Primary LASIK Original RX _____
 Repeat LASIK Enhance RX _____

Original BCVA 20/_____ Age _____ Aim Plano Mono

Exam Date _____

Day 1 _____ Week 1 2 3 Month 1 2 3 6 9 12

Meds (circle) Quixin Pred Forte Lubrication None

Autorefractation _____

UCVA 20/_____ (blurry / glare / double / fluctuates)

Refraction _____ 20/_____

Symptoms _____

Lasik Corneal Flap (circle)

Position excellent / dislodged / striae

Clarity clear / edema / haze

Interface clear / opacities / epithelial ingrowth

Edges smooth / rolled / eroded

IOP (after 1 week/applanation) _____ mm

Treatment _____

Doctor comments excellent stable enhancement

Follow up with comanaging doctor with SBVC

Next visit 1 2 3 4 5 6 _____ weeks / months

Comments

LEFT EYE

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Comments