Talley Eye Care

Refractive Surgery Post-Operative Data

Patient: ____________________ Exam Date: ____________

Referring Doctor Data

Doctor's Name: ____________________ Phone # (   ) ____________

Surgeon's Name: Dr. Dwight Silvera Phone # (   ) ____________

Procedure: PRK LASIK

Surgery OD: ________ Date: ________ Surgery OS: ________ Date: ________

Present Medications: ______________________________

Post Op: ________ Days ________ Week ________ Month ________ Other

Patient Symptoms: 0 = None; 1 = Minimal; 2 = Mild; 3 = Moderate; 4 = Severe

Symptoms:	OD	OS
Discomfort/Pain:		
Fluctuation of Vision:		
Glare/Reduced Night Vision:		

Symptoms:	OD	OS
Tearing		
Photophobia		
FB Sensation		

Other Symptoms (specify): ______________________________

K's or Corneal Topography
R ____________
L ____________

Refraction (Sphere Only)
OD ____________ VA OD: ________
OS ____________ VA OS: ________

Refraction (with Cylinder)
OD ____________ VA OD: ________
OS ____________ VA OS: ________

Slit Lamp
OD ____________
OS ____________

Impressions:

Recommendations:

Sig. ____________