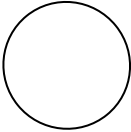
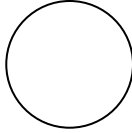


Post-Operative Exam

Patient Name: _____ Exam Date: _____ Visit Type: Day _____ Week _____ Month _____

CC: _____

OD Exam Results			OS Exam Results			
<input type="checkbox"/> LASIK	<input type="checkbox"/> Epi-LASEK	<input type="checkbox"/> PRK	Primary Procedure	<input type="checkbox"/> LASIK	<input type="checkbox"/> Epi-LASEK	<input type="checkbox"/> PRK
<input type="checkbox"/> AK	<input type="checkbox"/> Intacs			<input type="checkbox"/> AK	<input type="checkbox"/> Intacs	
<input type="checkbox"/> LASIK	<input type="checkbox"/> Epi-LASEK	<input type="checkbox"/> PRK	Retreatment Procedure	<input type="checkbox"/> LASIK	<input type="checkbox"/> Epi-LASEK	<input type="checkbox"/> PRK
<input type="checkbox"/> AK	<input type="checkbox"/> Intacs	<input type="checkbox"/> PTK		<input type="checkbox"/> AK	<input type="checkbox"/> Intacs	<input type="checkbox"/> PTK
Auto Refraction						
20/			UCVA Near	20/		
20/			UCVA Distance	20/		
20/			Manifest Refraction	20/		
IOP (after 1 wk PO)						
		Cornea				
LASIK-FLAP						
<input type="checkbox"/> Normal	<input type="checkbox"/> Dislodged	<input type="checkbox"/> Striae	Position	<input type="checkbox"/> Normal	<input type="checkbox"/> Dislodged	<input type="checkbox"/> Striae
<input type="checkbox"/> Smooth	<input type="checkbox"/> Roughened	<input type="checkbox"/> Abrasion	Surface	<input type="checkbox"/> Smooth	<input type="checkbox"/> Roughened	<input type="checkbox"/> Abrasion
<input type="checkbox"/> Clear	<input type="checkbox"/> Edema	<input type="checkbox"/> Haze	Clarity	<input type="checkbox"/> Clear	<input type="checkbox"/> Edema	<input type="checkbox"/> Haze
<input type="checkbox"/> Clear	<input type="checkbox"/> Opacities	<input type="checkbox"/> Epi-ingrowth	Interface	<input type="checkbox"/> Clear	<input type="checkbox"/> Opacities	<input type="checkbox"/> Epi-ingrowth
<input type="checkbox"/> Heme	<input type="checkbox"/> Infiltrates			<input type="checkbox"/> Heme	<input type="checkbox"/> Infiltrates	
PRK-Epi-LASEK						
<input type="checkbox"/> On	<input type="checkbox"/> Off		BCL	<input type="checkbox"/> On	<input type="checkbox"/> Off	
<input type="checkbox"/> None	<input type="checkbox"/> +1	<input type="checkbox"/> +2	<input type="checkbox"/> +3	<input type="checkbox"/> +4	<input type="checkbox"/> None	<input type="checkbox"/> +1
<input type="checkbox"/> None	<input type="checkbox"/> +1	<input type="checkbox"/> +2	<input type="checkbox"/> +3	<input type="checkbox"/> +4	<input type="checkbox"/> None	<input type="checkbox"/> +1
Epi-Defect Impression						
Plan						
Shield/Goggles for _____ nights			Patient Instructions	Shield/Goggles for _____ nights		
TobraDex QID x _____ days				TobraDex QID x _____ days		
Artificial Tears PRN <input type="checkbox"/> Yes <input type="checkbox"/> No				Artificial Tears PRN <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Voltaren Ophth. Gtts.				<input type="checkbox"/> Voltaren Ophthal. Gtts.		
<input type="checkbox"/> Mepergan Fortis (1) q6h prn/pain				<input type="checkbox"/> Mepergan Fortis (1) q6h prn/pain		
Other: _____				Other: _____		

Doctor's Signature: _____
Doctor's Phone: _____