Price Vision Group – LASIK Post-op Report

Patient Name: _____ Date:_____
Date of LASIK: _____ OD/OS/OU Type of Visit: 1 day/1 wk/1mos/Other _____

Uncorrected Vision: 20/_____ OD **All Medications:**
20/_____ OS **Change in Systemic Meds? Yes No**

Manifest Refraction:(required at 1mos and 3mos) **Cycloplegic Refraction: (Only if enhancement needed)**

OD: 20/_____ **OD: 20/_____**

OS: 20/_____ **OS: 20/_____**

Slit Lamp Exam (Please circle findings: Explain anything less than normal)

OU OD OS Conjunctiva – White (or minimal subconjunctival hemorrhage)

OU OD OS Cornea : Clear (cap well positioned; no defect, haze or wrinkles)

OU OD OS Anterior Chamber : Deep & Quiet

OU OD OS Lens : clear (or no increase in cataract change from before LASIK)

Intraocular Pressure: (Not until 1mos exam)

_____ mmHg OD

_____ mmHg OS

Assessment: _____

Plan: _____

Recheck: ____ day/week/month My office PVG office

EXAM CHECKED BY:

_____ _____
Signature Dr. Name (Please Print)

Fax to : 317- 814 – 2848 attn: Refractive