POST OPERATIVE EVALUATION

INSIGHT LASIK & Refractive Group

Patient Name:_____ **Date**:_____

Surgery Date: OD _____/_____/_____ OS _____/_____/_____

Procedure Performed: LASIK PRK RK AK LTK

AR: OD _____ OS _____

***If enhancement,** original surgery dates: OD _____/_____/_____ OS _____/_____/_____

PATIENT HISTORY:

_____

_____

Current Medications: OD_____ OS_____

	UCVA	PH	J	Patient Satisfaction
OD	20/ ____	20/ ____	____	1 2 3 4 5
OS	20/ ____	20/ ____	____	1 2 3 4 5

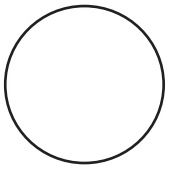
	REFRACTION	CYCLOPLEGIC
OD	_____-_____x_____	_____-_____x_____
OS	_____-_____x_____	_____-_____x_____

	Flat	Steep	Steep Axis
K Readings OD	_____/_____x_____		
OS	_____/_____x_____		

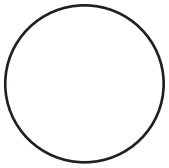
IOP Goldman/NCT
OD_____ OS_____

LASIK Cap

	OD		
Position:	Normal	Dislodged	Decentered
Clarity:	Normal	Folds	Haze
Interface:	Normal	Opacities	Epithelial Ingrowth
Edges:	Normal	Rolled	Erode



	OS		
Position:	Normal	Dislodged	Decentered
Clarity:	Normal	Folds	Haze
Interface:	Normal	Opacities	Epithelial Ingrowth
Edges:	Normal	Rolled	Erode



PRK

OD: BCL:	In Place	Decentered	Absent	Removed	Defect: _____MM
OS: BCL:	In Place	Decentered	Absent	Removed	Defect: _____MM

Haze: OD	None	1	2	3	4
OS	None	1	2	3	4

RK/AK

Incisions Healed: OD: Yes No OS: Yes No

LTK

Epithelium Intact: OD: Yes No OS: Yes No

Current Plan:

_____

_____

Doctor Signature: _____ Next Appointment: _____