



9989 SW Nimbus Ave. ❖ Beaverton, OR 97008
503-520-0800 ❖ 800-422-7014 ❖ Fax 503-520-0403

Refractive Surgery Postoperative Evaluation Report

Date of Exam _____ Referring Doctor _____

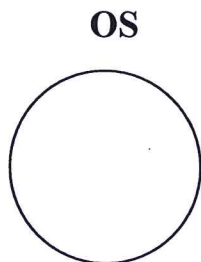
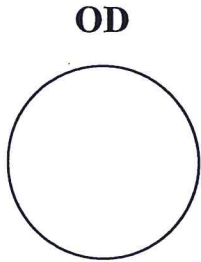
Patient _____

Surgery OD _____ Date _____
OS _____ Date _____

Meds OD _____ OS _____

History _____

V_s OD 20/____ Manifest OD _____ =20/____
OS 20/____ Refraction OS _____ =20/____



Flap Position: Normal Striae
Interface: Normal Epi Cells Haze
Glare: Yes No

Impression _____ Plan _____

Next Visit ____/____/____, OD