

Name _____ Age _____ Tx: PRK OD OS OU

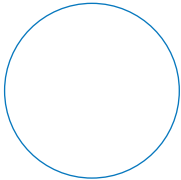
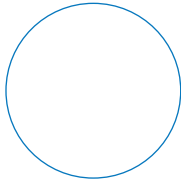
Co-Managing Doctor _____ Doctor Phone _____ Doctor Fax _____ Doctor Email _____

Original Treatment Date _____ Post-operative Visit Day _____ Week _____ Month _____

Med: / Dosage: Pred Forte _____ Zymar _____ Acular/Voltaren _____ FML _____

Artificial Tears: PF Regular _____

OD Target: Plano Other _____ OS Target: Plano Other _____

UCDVA	20 / blurry glare dbl fluctuates					20 / blurry glare dbl fluctuates				
Refraction	_____ 20 /					_____ 20 /				
SLIT LAMP	CORNEAL CLARITY	HAZE GRADE	HAZE PATTERN	CORNEAL CLARITY	HAZE GRADE	HAZE PATTERN				
		Clear Trace Reticular Mild Reticular Moderate Confluent Severe Confluent	Diffuse Focal Arcuate		Clear Trace Reticular Mild Reticular Moderate Confluent Severe Confluent	Diffuse Focal Arcuate				
IOP	_____ mmHg					_____ mmHg				

Next followup visit scheduled: _____ day week month year Follow up required with LVL? **Y** **N**

Doctor's Comments/Treatment: excellent stable enhancement

Dr. Signature _____

Date _____