

POST-OPERATIVE ASSESSMENT FORM

Follow-up Date: ___/___/___

Patient's Name: _____ OD OS OU

Surgeon: C. Dan Siapco, MD Carlindo Pereira, MD

Surgery Date: ___/___/___ Co-Managing Doctor: _____

Procedure:

Monofocal IOL Toric IOL ReSTOR PRK LASIK (Intralase)

OD 1 Day 1 Week 1 Month 6 Months


OS 1 Day 1 Week 1 Month 6 Months


Other OD _____ OS _____

(Include slit lamp and dilated fundus as needed.)

Subjective Findings: _____

Patient opinion of night vision (same, better, worse) _____ Patient satisfaction (0-4) _____

Assessment: OD
VA sc 20/ _____
Refraction: _____ 20/ _____
Keratometry _____ / _____ @ _____
(auto/manual)
Cornea ___ Clear Other _____

Intraocular Pressure: _____ mm/hg

Assessment: OS
VA sc 20/ _____
Refraction: _____ 20/ _____
Keratometry _____ / _____ @ _____
(auto/manual)
Cornea ___ Clear Other _____

Intraocular Pressure: _____ mm/hg

Medications: _____

Impression/Comments: _____

Next planned Visit: _____ Doctor signature: _____

PLEASE FAX COMPLETED FORM TO 360.424-6854 Attn: Vicki