TAMC Laser Refractive Surgery Center

Name: _____ **Date of Birth:** _____

LASIK–OU
DATE OF SX: _____

- ❑ Post-Operative Day # ____
- ❑ ___ Week(s) Post-Op
- ❑ ___ Month(s) Post-Op

Medications
- ❑ Vigamox OU QID
- ❑ Pred Forte OU QID
- ❑ Vicodin/Roxicet prn
- ❑ Art Tears prn
- ❑ Other _____

Eye Pain (scale 0-10): __/10 OD, __/10 OS
Dry Eyes (scale 0-5): ___/5 OD, ___/5 OS
Glare/Halos(scale 0-5): ___/5 OD, ___/5 OS

Visual Acuity sc: OD: 20/ ___ PH 20/ ___ IOP OD:
OS: 20/ ___ PH 20/ ___ OS:

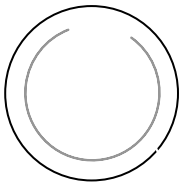
___ Smoke
___ Alcohol
___/10 Pain

Auto Refraction: OD _____, - _____ x _____
OS _____, - _____ x _____

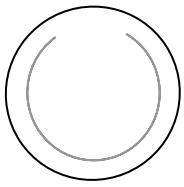
MRx: OD _____, - _____ x _____ (20/ __)
OS _____, - _____ x _____ (20/ __)

Slit Lamp Exam:

K:



OD		OS
❑	1. Epith defect	❑
❑	2. Interface debris	❑
❑	3. Epith ingrowth	❑
❑	4. Infiltrate	❑
❑	5. Microstriae	❑
❑	6. Macrostriae	❑
❑	7. DLK Stage __	❑



Impression: 1. stable s/p bilateral LASIK
2. Other:

Plan:
- ❑ Pred Forte OU QID x 1 week post-op, then stop
- ❑ Vigamox OU QID x 1 week post-op, then stop
- ❑ Artificial Tears prn
- ❑ Punctal plug(s) placed
- ❑ follow-up appointment: (scheduled visits at 1 week; 1,3 & 6 months)

❑ ___ day(s)		
❑ 1 week post-op visit	With	❑ Laser Clinic Optometrist
❑ 1 3 6 month post-op visit		❑ Ophthalmology
❑ Every 1-2 years		❑ Your regular optometry clinic

Physician's Signature _____ DATE: _____

Physician's Stamp_____ SURGI: _____