Lasik Vision Centers of Cleveland

PRK Post Op

FAX To 216.674.6410

Patient : _____ Date of birth : _____ Age : _____

Affiliate :_____ Phone : _____ Fax : _____

Procedure Date:_____

OD

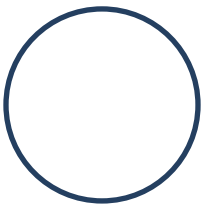
Post Op exam date : ____ ____ Day/ Week / Month/Yr. (from surgery)

Patient comments : _____

Meds : _____

UCVA : 20/ _____ Manifest _____ 20/_____

Refraction (1 mo& 3mo)_____20/____

Corneal Evaluation	Degree of haze	Pattern of haze
	Clear / Trace Mild / Moderate Severe	Diffuse Focal Arcuate

Summary : Excellent / Stable / LVC to Evaluate / Other

Follow Up / Treatment / Comments : _____

_____

_____

Affiliate : _____

OS

Post Op exam date :____ ____ Day / Week/ Month/Yr. (from surgery)

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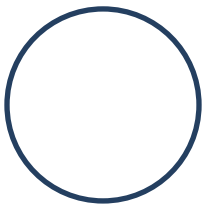	Clear / Trace Mild / Moderate Severe	Diffuse Focal Arcuate

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Follow Up / Treatment / comments : _____

_____

_____

Date _____