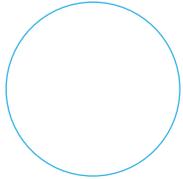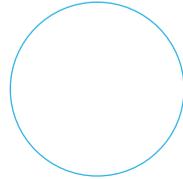Name _____ D.O.B. _____ Tx: PRK OD OS OU

Co-Managing Dr. _____ Dr. Phone_____ Dr. Fax _____ Dr. Email _____

Surgery Date_____ Post-operative Visit Day _____ Week _____ Month _____

Med: / Dosage: Vigamox _____ Nevanac _____ Lotemax _____ 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** Clear Trace Reticular Mild Reticular Moderate Confluent Severe Confluent	**HAZE PATTERN** Diffuse Focal Arcuate	**CORNEAL CLARITY**	**HAZE GRADE** Clear Trace Reticular Mild Reticular Moderate Confluent Severe Confluent	**HAZE PATTERN** Diffuse Focal Arcuate
IOP	_____ mmHg			_____ mmHg		

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

Doctor's Comments/Treatment: excellent stable enhancement

_____

_____

Dr. Signature _____   Date _____