



Refractive Surgery Post-Operative Data

Patient Name: _____ Exam Date: _____

Referring Doctor: _____ Phone Number: _____

Performing Surgeon: Dwight A. Silvera, M.D.

Procedure: PRK LASIK

Date of Surgery: OD: _____ OS: _____

Present Medications: _____

Post-Op: _____ Days _____ Weeks _____ Months

Patient Symptoms: 0 = None, 1 = Minimal, 2 = Mild, 3 = Moderate, 4 = Severe

Symptom:	OD	OS	Symptom:	OD	OS
Discomfort / Pain:	_____	_____	Tearing:	_____	_____
Fluctuation of Vision:	_____	_____	Photophobia:	_____	_____
Glare / Reduced Night Vision:	_____	_____	Foreign Body Sensation:	_____	_____

Other Symptoms (Please Specify): _____

K's / Corneal Topography: OD: _____
 OS: _____
 Refraction OD: _____
 OS: _____

VA OD: 20/_____
 VA OS: 20/_____

Slit Lamp: OD

Cornea: ☐ Clear ☐ Abnormal _____
 Anterior Chamber: ☐ Clear ☐ Cells: 1+ 2+ 3+ 4+
 LASIK Flap: ☐ Clear ☐ Abnormal _____

OS

Cornea: ☐ Clear ☐ Abnormal _____
 Anterior Chamber: ☐ Clear ☐ Cells: 1+ 2+ 3+ 4+
 LASIK Flap: ☐ Clear ☐ Abnormal _____

Impressions: _____

Recommendations: _____

Signature _____