Print Form

Lasik Post-op Evaluation (form c)

Grand Valley LASIK Institute

Patient Information
Last Name _____ First Name _____

Co-managing Doctor _____
e-mail Phone Fax

Right Eye Information

Procedure Date Month _____ Day _____ Year _____

Procedure Type ◯ Custom LASIK ◯ Conventional LASIK ◯ Repeat LASIK ☐ Original Rx _____ ☐ Enhance Rx _____

Original BCVA _20/_____ **Age** _____ **Target** ☐ Plano ☐ Mono

Right Eye Exam

Date Month _____ Day _____ Year _____

Circle Day _____ Week 1 2 3 ☐ Month 1 2 3 6 9 12 ☐

Meds ☐ Zymar ☐ Pred Forte ☐ Lubrication

Auto Refraction _____

UCVA 20/ ☐ blurry ☐ glare ☐ double ☐ fluctuates

Refraction _____

Symptoms _____

LASIK Corneal Flap

Position	☐ excellent	☐ dislodged	☐ striae
Clarity	☐ clear	☐ edema	☐ haze
Interface	☐ clear	☐ opacities	☐ epithelial ingrowth
Edges	☐ smooth	☐ rolled	☐ eroded

IOP (after 1 week/applanation) _____ mm

Treatment _____

Doctor Comments ☐ excellent ☐ stable ☐ enhancement

Enhancement ☐ myoia ☐ hyperopia ☐ cylinder ☐ epithelial ingrowth ☐ central island ☐ GVL to contact patient ☐ Patient will call GVL

Follow-up ☐ with co-managing doctor ☐ with GVL

Next Visit In 1 2 3 4 5 6 ☐ ☐ weeks ☐ months

Comments _____

Left Eye Information

Procedure Date Month _____ Day _____ Year _____

Procedure Type ◯ Custom LASIK ◯ Conventional LASIK ◯ Repeat LASIK ☐ Original Rx _____ ☐ Enhance Rx _____

Original BCVA _20/_____ **Age** _____ **Target** ☐ Plano ☐ Mono

Left Eye Exam

Date Month _____ Day _____ Year _____

Circle Day _____ Week 1 2 3 ☐ Month 1 2 3 6 9 12 ☐

Meds ☐ Zymar ☐ Pred Forte ☐ Lubrication

Auto Refraction _____

UCVA 20/ ☐ blurry ☐ glare ☐ double ☐ fluctuates

Refraction _____

Symptoms _____

LASIK Corneal Flap

Position	☐ excellent	☐ dislodged	☐ striae
Clarity	☐ clear	☐ edema	☐ haze
Interface	☐ clear	☐ opacities	☐ epithelial ingrowth
Edges	☐ smooth	☐ rolled	☐ eroded

IOP (after 1 week/applanation) _____ mm

Treatment _____

Doctor Comments ☐ excellent ☐ stable ☐ enhancement

Enhancement ☐ myoia ☐ hyperopia ☐ cylinder ☐ epithelial ingrowth ☐ central island ☐ GVL to contact patient ☐ Patient will call GVL

Follow-up ☐ with co-managing doctor ☐ with GVL

Next Visit In 1 2 3 4 5 6 ☐ ☐ weeks ☐ months

Comments _____