



Orange
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Orange, CA 92868

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Irvine, CA 92618

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Long Beach
4300 Long Beach Blvd., Ste 400
Long Beach, CA 90807

Norco
1524 4th St.
Norco, CA 92860

Fax (714) 771-7126

Post- Operative Form

Referring Doctor: _____ Fax Number: _____

Patient Name: _____ DOB: _____ Exam Date: _____

Procedure: OD: Cataract/RLE LASIK/PRK Enhancement ICL Other _____
OS: Cataract/RLE LASIK/PRK Enhancement ICL Other _____
Date of Latest Surgery: OD _____ OS _____
Post-op Visit: 1 day 1 week 1 Month 3 Months 6 Months 1 Year

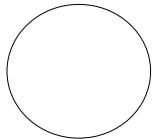
Patient's Symptoms: _____

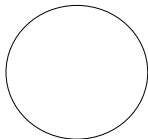
Current Medications: _____

Uncorrected VA: Distance OU 20/ Near OU J Tonometry: (Time)
Distance: OD 20/ OS 20/ OD (APL TP)
Near: OD J OS J OS (APL TP)

Manifest Refraction Cycloplegic Refraction
OD _____ X _____ 20/ _____ J _____ OD _____ X _____ 20/ _____
OS _____ X _____ 20/ _____ J _____ OS _____ X _____ 20/ _____

Slit Lamp Exam

Lids
Conjunctiva
Cornea
Interface:
(LASIK Only) WNL
Hazy 1+ 2+ 3+ 4+
Debris 1+ 2+ 3+ 4+ 

Lids
Conjunctiva
Cornea
Interface:
(LASIK Only) WNL
Hazy 1+ 2+ 3+ 4+
Debris 1+ 2+ 3+ 4+ 

Cornea Clarity/Edema Grading OD
 Clear Trace Mild Moderate Severe

Cornea Clarity/Edema Grading OS
 Clear Trace Mild Moderate Severe

Anterior Chamber
Lens

Anterior Chamber
Lens

Fundus

Fundus

Comments: _____

Doctor's Signature: _____ Date: _____