TALLEY EYE INSTITUTE

Refractive Surgery Post-Operative Data

Patient Name: _____ Exam Date: _____

Referring Doctor: _____ Phone Number: _____

Performing Surgeon: Dwight A. Silvera, M.D. Phone Number: _____

Procedure: PRK LASIK

Date of Surgery: OD: _____ OS: _____

Present Medications: _____

Post-Op: _____ Days _____ Weeks _____ Months _____ Other

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 or Corneal Topography: OD: _____
OS: _____

Refraction (Sphere Only) OD: _____ VA OD: _____
OS: _____ VA OS: _____

Refraction (with Cylinder) OD: _____ VA OD: _____
OS: _____ VA OS: _____

Slit Lamp: OD: _____
OS: _____

Impressions: _____

_____

Recommendations: _____

_____

Signature _____

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