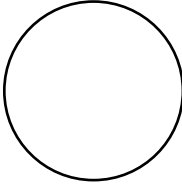
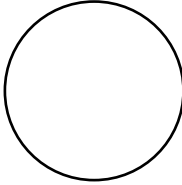


## POST-OPERATIVE ASSESSMENT

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_  
 Surgery Date: \_\_\_\_\_ OD/OS Procedure: \_\_\_\_\_  
 Surgery Date: \_\_\_\_\_ OD/OS Procedure: \_\_\_\_\_  
 Primary Eye Care Doctor: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Surgeon: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Post-Op Dates: 1-Week \_\_\_\_\_ 1-Month \_\_\_\_\_ Assessment: \_\_\_\_\_

				OD	OS
Visual Acuity (Uncorrected)				20/	20/
<b>MR: OD</b>				20/	
<b>MR: OS</b>					20/
IOP's (Applanate)				mmHg	mmHg
SLITLAMP:				OD	OS
Conj: Normal/					
Cornea: Normal/					
A/C: Normal/					
Iris: Normal/					
Lens: Normal/					
Medications/Dosages: _____ _____ _____					

Assessment/Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Appointment made for patient with Dr. \_\_\_\_\_ on \_\_\_\_\_ at \_\_\_\_\_  
 Additional instructions for patient: \_\_\_\_\_  
 \_\_\_\_\_

Examining Doctor: \_\_\_\_\_ Date: \_\_\_\_\_