Hollingshead Eye Center, P.C.℠

See the difference experience makes™

LASIK FOLLOW-UP

Optometrist: _____

FAX TO:208- 426- 0902

Patient _____ Age: _____ DOB: _____ Date: _____

Surgery Date: _____ ☐ **Original** ☐ H – LASIK ☐ Enhancement ☐ _____

OD: ☐ Day 1_____ ☐ 1 Week ☐ 1 Month ☐ 4 Months ☐ 10 Months ☐ 1 Year ☐ Unscheduled Visit _____

OS: ☐ Day 1 _____ ☐ 1 Week ☐ 1 Month ☐ 4 Months ☐ 10 Months ☐ 1 Year ☐ Unscheduled Visit _____

CC / HPI: _____

_____

Current Meds:

OD: ☐ Zymaxid____ ☐ Durezol_____ ☐ Tears _____ ☐ Acular _____ ☐ Other _____

OS: ☐ Zymaxid____ ☐ Durezol_____ ☐ Tears _____ ☐ Acular _____ ☐ Other _____

Examination:

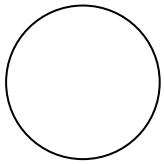
Va sc
OU 20/ _____
OD 20/ _____
OS 20/ _____

IOP (3mos)
OD: _____
OS: _____

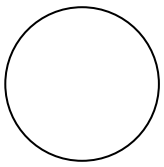
Manifest Refraction
OD: _____ 20/ _____
OS: _____ 20/ _____

Cyclo Refraction
OD: _____ 20/ _____
OS: _____ 20/ _____

Slit Lamp Exam	**OD**
Subconjunctival Hemorrhage	☐
Epithelium	
Normal	☐
SPK	☐
Ingrowth	☐
Defect	☐
Flap	
Normal	☐
Edema	☐
Microstriae	☐
Folds	☐
Interface	
Normal	☐
Debris	☐
Diffuse Lamellar Keratitis	☐



Slit Lamp Exam	**OS**
Subconjunctival Hemorrhage	☐
Epithelium	
Normal	☐
SPK	☐
Ingrowth	☐
Defect	☐
Flap	
Normal	☐
Edema	☐
Microstriae	☐
Folds	☐
Interface	
Normal	☐
Debris	☐
Diffuse Lamellar Keratitis	☐



Assessment: _____

_____

_____

Plan: _____

_____

Follow-up: 1 2 3 4 5 6 days / weeks / months / yrs

Tech: _____

Doctor: _____