Hollingshead
Eye Center, P.C.℠

See the difference experience makes™

208-336-8700

FAX TO: 208-426-0902

CATARACT / YAG FOLLOW-UP **Optometrist:** ______________

Name: ________________________________ Age: ________ Exam Date: ____________________

Date of Surgery: ________________________

OD: ☐ Day 1 ☐ 1 Week ☐ 3 Weeks ☐ Other __________ **OS**: ☐ Day 1 ☐ 1 Week ☐ 3 Weeks ☐ Other __________

CC / HPI: ____

____

____

OD

Visual Acuity without Rx: 20/ ______ Pin Hole 20/______

IOP (Air / Applanation) ________________mm Hg

Keratometry __________ / __________

Refraction ________ - ________ x ______ 20/ _____

Slit Lamp Exam	**Normal**	**Abnormal**
Lids / Lashes	☐	☐ ______________
Conjunctiva	☐	☐ ______________
Cornea	☐	☐ ______________
		______________
Ant. Chamber	☐	☐ ______________
Lens / IOL	☐	☐ ______________

OS

Visual Acuity without Rx:: 20/ ______ Pin Hole 20/______

IOP (Air / Applanation) ________________mg Hg

Keratometry __________ / __________

Refraction ________ - ________ x ______ 20/_____

Slit Lamp Exam	**Normal**	**Abnormal**
Lids / Lashes	☐	☐ ______________
Conjunctiva	☐	☐ ______________
Cornea	☐	☐ ______________
		______________
Ant. Chamber	☐	☐ ______________
Lens / IOL	☐	☐ ______________

Notes ____

____

____

____

Co-Managing Practice Information:

Optometrist: ________________________ Telephone: ______________ Fax: __________

Examiner Signature: ________________________ Address: ________________________