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____ ☐ Pred Forte______ ☐ Tears ________ ☐ Other __________

OS: ☐ Zymaxid____ ☐ Pred Forte ______ ☐ Tears ________ ☐ Other __________

Examination:

Va sc OU 20/ _______ OD 20/ ________ OS 20/ ________

IOP (3mos)
OD: ______
OS: ______

Manifest Refraction

OD: ______________________ 20/ _______

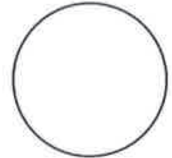
OS: ______________________ 20/ _______

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	☐
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Flap	
Normal	☐
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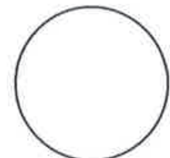
Diffuse Lamellar Keratitis	☐



Assessment: ____

____

____

Plan: ____

____

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

Tech: ______________________

Doctor: ______________________