

*Talley Medical-Surgical Eye Care Associates, P.C.*

**REFRACTIVE SURGERY POST-OPERATIVE DATA**

Patient: \_\_\_\_\_ Exam Date: \_\_\_\_\_

**Referring Doctor Data:**

Doctor's Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Surgeon's Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Procedure: RK AK PRK LK LASIK Other: \_\_\_\_\_

Surgery OD \_\_\_\_\_ Date: \_\_\_\_\_ Surgery OS: \_\_\_\_\_ Date: \_\_\_\_\_

Present Medications: \_\_\_\_\_

**Post-Op:** \_\_\_\_\_ days \_\_\_\_\_ week \_\_\_\_\_ month other \_\_\_\_\_

**Patient Symptoms:** (0 = None, 1 = Minimal, 2 = Mild, 3 = Moderate, 4 = Severe)

Symptoms:	OD	OS	Symptoms:	OD	OS
Discomfort / Pain	_____	_____	Tearing	_____	_____
Fluctuation of Vision	_____	_____	Photophobia	_____	_____
Glare / Reduced Night Vision	_____	_____	FB Sensation	_____	_____

Other symptoms (specify) \_\_\_\_\_

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**V<sub>SC</sub> <**      **T <**      K's or R \_\_\_\_\_  
Corneal Topography      L \_\_\_\_\_

Refraction (sphere only): O.D. \_\_\_\_\_ VA OD: \_\_\_\_\_  
O.S. \_\_\_\_\_ VA OS: \_\_\_\_\_

Refraction (with cylinder): O.D. \_\_\_\_\_ VA OD: \_\_\_\_\_  
O.S. \_\_\_\_\_ VA OS: \_\_\_\_\_

Slit Lamp: O.D. \_\_\_\_\_  
O.S. \_\_\_\_\_

Impressions:

Recommendations: \_\_\_\_\_ Sig. \_\_\_\_\_