

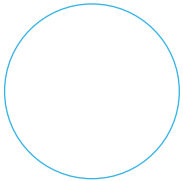
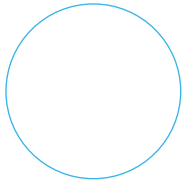
Name _____ Age _____ Tx: PRK OD OS OU

Co-Managing Doctor _____ Doctor Phone _____ Doctor Fax _____ Doctor Email _____

Original Treatment Date _____ Post-operative Visit Day _____ Week _____ Month _____

Med: / Dosage: Maxidex _____ Zymar _____ Other _____ Artificial Tears: PF Regular _____

OD Target: Plano Other _____ OS Target: Plano Other _____

UCDVA	20 / blurry glare dbl fluctuates				20 / blurry glare dbl fluctuates			
Refraction	_____ 20 /				_____ 20 /			
SLIT LAMP	CORNEAL CLARITY	HAZE GRADE	HAZE PATTERN	CORNEAL CLARITY	HAZE GRADE	HAZE PATTERN		
		Clear Trace Reticular Mild Reticular Moderate Confluent Severe Confluent	Diffuse Focal Arcuate		Clear Trace Reticular Mild Reticular Moderate Confluent Severe Confluent	Diffuse Focal Arcuate		
IOP	_____ mmHg			_____ mmHg				

Next followup visit scheduled: _____ day week month year Follow up required with BLEC? Y N

Doctor's Comments/Treatment: excellent stable enhancement
