



Surgical Follow-up: 1-DAY 1-WEEK 1-MONTH 3-MONTH 6-MONTH

Patient Name: _____ Date: _____

Date of Surgery: OD _____ OS _____

Surgical Procedure: OD _____ OS _____

Surgical Goal: OD _____ OS _____

Eye Meds: _____

Chief Complaint: _____

IOP:
Time _____
OD _____
OS _____

OD

OU

OS

Uncorrected Visual Acuity:

Dist. VA 20/ _____

Dist. VA 20/ _____

Dist. VA 20/ _____

Near VA _____ @ _____

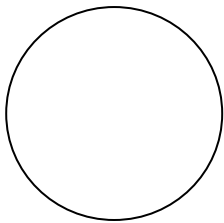
Near VA _____ @ _____

Near VA _____ @ _____

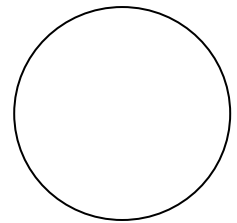
MR _____ X _____ 20/
Add _____

OU: 20/ _____ X _____ 20/
Add _____

0= none/normal, 1= trace, 2= mild, 3= moderate, 4= severe



- Conjunctiva
Cornea
Wound
Anterior Chamber
Iris
Lens
Capsule
Vault



Suture: Yes / No

Suture: Yes/ No

Assessment: _____

Plan: _____ To see: _____ In: _____

Eye Meds: _____

Comments: _____ Dr: _____