



LASIK Follow Up Form

Please fax to (717) 233-5715

<u>Patient's information</u>	<u>Present Medication Regime</u>	
Name _____ Last First MI	Patient Compliance	OD OS Y/N Y/N
DOB _____ Date of Exam: _____	No Meds	_____
Surgeon _____	1. Antibiotic	_____ id/ d/ od _____ id/ d/ od
Co - Managing Doctor _____	2. Steroid	_____ id/ d/ od _____ id/ d/ od
	3. Artificial Tears	_____ id/ d/ od _____ id/ d/ od
	4. Other	_____ id/ d/ od _____ id/ d/ od
Primary LASIK Date _____ Enhancement Date _____	<u>Corneal Surface</u>	<u>Interface</u>
	OD OS	OD OS
LASIK Enhancement	Normal	0 Normal
AST (Advance Surface Treatment)	Punctate Erosions	1 Debris
Follow Up Visit	Epithelial Defect	2 Haze
First (Day 1-3)	Irregular Epithelium	3 Inflamed
1 Week		4 Striae
1 Month		5 Epithelium
3 Month		
6 Month		
1 Year		
Lost to Follow Up		
Unscheduled Visit*		
If unscheduled, state reason below:	<u>Patient Symptoms</u>	OD OS
	(enter 0-4)	
	FB Sensation	_____
	Discomfort/Pain	_____
	Tearing	_____
	Photophobia	_____
	Visual Fluctuation	_____
	Glare	_____
	<u>Other Findings:</u>	
<u>Clinical Data</u>	<u>Medication Plan</u>	
<u>Distance</u>	OD OS	OS
Va sc OD 20/_____ PH OD 20/_____	No Med	_____
OS 20/_____ PH OS 20/_____	Patch/ung	_____ id/ d/ od _____ id/ d/ od
<u>Near</u>	Antibiotic	_____ id/ d/ od _____ id/ d/ od
Va sc OD 20/_____ PH OD 20/_____	Steroid	_____ id/ d/ od _____ id/ d/ od
OS 20/_____ PH OS 20/_____	Artificial Tears	_____ id/ d/ od _____ id/ d/ od
	Other	_____ id/ d/ od _____ id/ d/ od
<u>Manifest Refraction</u>	<u>RTC:</u>	
OD _____ x _____ 20/_____ VD _____	<u>Comments:</u>	
OS _____ x _____ 20/_____ VD _____		
Add: _____		
<u>Keratometry</u> (or topography simK's)	<u>Patient Satisfaction</u> (circle)	
OD _____ x _____	Very Happy 1 2 3 4 5 Unhappy	
OS _____ x _____		
Flat Steep Steep Axis		
<u>IOP</u> OD _____ mmHg OS _____ mmHg	<u>Doctor's Signature</u>	
	X _____	