Diagnostic Eye Center

1 Week LASIK Post-Op Report

*Please fax your exam findings to **713-797-1150**. Our surgeons rely on this data, and we appreciate your help!*

Patient Name: ______________________________ **DOB:** ____________

Date of Exam: ______________

Uncorrected Distance VA

OD: 20/_______

OS: 20/_______

Uncorrected Near VA (if monovision)

OD: J _______

OS: J _______

Slit Lamp Examination:

□ LASIK flaps in place

Comments: ______________________________

How do you rate this patient's satisfaction?

□ Very Satisfied □ Satisfied □ Neutral □ Dissatisfied □ Very Dissatisfied

Comments: ______________________________

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Examining Physician (print name): ______________________________

Signature: ______________________________

Please contact us by telephone at 713-797-1500 if you need assistance with any post-operative condition.