



Diagnostic Eye Center
3-4 Month LASIK Post-Op Report
(Hyperopic LASIK and any Surface Ablation treatments)

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 _____

Refraction

OD: _____ 20/_____

OS: _____ 20/_____

Slit Lamp Examination:

LASIK flaps in place

Comments: _____

How do you rate this patient's satisfaction?

Very Satisfied

Satisfied

Neutral

Dissatisfied

Very Dissatisfied

Comments: _____

Examining Physician (print name): _____

Signature: _____

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