



Diagnostic Eye Center
4-6 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 _____

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.