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.