



Patient Name: _____

Patient DOB: _____

Co-managing: _____

Procedure: Primary Enhancement

Target: OD _____ OS _____

OD

OS

Surgery Date: Month _____ Day _____ Year _____

Exam Date: Month _____ Day _____ Year _____

Post-op Visit: 1 day 1 week 3 month

Surgery Date: Month _____ Day _____ Year _____

Exam Date: Month _____ Day _____ Year _____

Post-op Visit: 1 day 1 week 3 month

HISTORY

Doing Well Other _____

Doing Well Other _____

OCULAR MEDICATIONS

PMNTID ATs None

PMNTID ATs None

VISION

UCVA: 20/ _____

MR: _____ 20/ _____

UCVA: 20/ _____

MR: _____ 20/ _____

SLIT LAMP FLAP EVALUATION

Position: excellent striae
 Clarity: clear edema
 Interface: clear opacities ingrowth
 Other: _____

IOP (at 1 month visit): _____ mmHg

Position: excellent striae
 Clarity: clear edema
 Interface: clear opacities ingrowth
 Other: _____

IOP (at 1 month visit): _____ mmHg

IMPRESSION

Excellent Other _____

Excellent Other _____

PLAN

Continue Present Management Other

RTC _____ day(s) week(s) month(s) year

Refer back to Eye Surgeons of Indiana for evaluation

Striae Enhancement Other

Please Call Patient Appt Made ____/____/____

Continue Present Management Other

RTC _____ day(s) week(s) month(s) year

Refer back to Eye Surgeons of Indiana for evaluation

Striae Enhancement Other

Please Call Patient Appt Made ____/____/____

Doctor Signature: _____

Date: _____