PHOTOREFRACTIVE KERATECTOMY (PRK) and LASER ASSISTED IN SITU KERATOMEULESIS (LASIK)

PATIENT'S NAME: ____________________________ FILE No. ____

Date of Surgery: _________________________________ Surgical Technique: ___________________________

Number of treatments: __________________________ Size(s) of Ablation Zone(s): ______________________

UNCORRECTED ACUITY	REFRACTION & CORRECTED ACUITY
Pre-operative data:	
OD __________	______________________ = ______________________
OS __________	______________________ = ______________________
3 Months Post PRK: *(may be completed by an Optometrist)*	
OD __________	______________________ = ______________________
OS __________	______________________ = ______________________
6 Months Post PRK: *(may be completed by an Optometrist)*	
OD __________	______________________ = ______________________
OS __________	______________________ = ______________________

Are there any of the following:

Glare sensitivity or "haloing" . . . . Yes _____ No _____

Night vision difficulty . . . . Yes _____ No _____

Diurnal variation of vision . . . . Yes _____ No _____

Use of ocular medication . . . . Yes _____ No _____

Corneal haze . . . . Yes _____ No _____

Loss of contrast sensitivity/acuity *(this has potentially serious implications in the aviation environment)* . . . . .Yes _____ No _____

Signature of attending Ophthalmologist/ Optometrist ____

Date: _________________________________ Phone: ( ) ___________________________________