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Patient Post-OP EXAM

DATE:________________
PATIENT NAME: ____
REFERRING DOCTOR: ____
CATARACT EXTRACTION EYE: _____________ SURGERY DATE: __________________
MEDICATIONS ___________________________ EYE _______ QID☐ TID☐ BID☐ QD☐
ADDITIONAL MEDICATIONS ____

EXAMINATION OF OPERATED EYE

POST-OP VISIT: DAY ONE WEEK 1 2 3 4 5 6 7 8 9 10 11 12

VA WITHOUT CORRECTION 20/_______ PINHOLE 20/_______
MANIFEST REFRACTION ______________________________ VA______________________

SLIT LAMP EXAM (CIRCLE WITH COMMENTS)

WOUND/SUTURES INTACT_______________________SEIDEL________________________
CORNEA CLEAR___________________STRIAE__________________EDEMA___________

A/C CLEAR 1 + 2 + 3 + 4 + CELL/FLARE

IOL CENTERED___________________DECENTERED___________________

POST CAPSULE CLEAR______________HAZY _______________WRINKLED___________

MACULA NORMAL___________________CYSTOID_________________AMD___________

FUNDUS____

TENSIONS (APPLICATION/NCT)____________________mmHg@_________AM or PM

IMPRESSION/PLAN:____
____
____
____

SIGNATURE: ____

****IMMEDIATE Consultation indicated for any severe pain and/or decrease in vision****