

Cataract | LASIK | PRK Follow Up

(please circle)

Patient Name:							
Patient DOB: Date of Exam:							
Referring Doctor Name:							
Office Name:							
Visit Type: (please circle) 1 Month 3 Month 6 Month Other:							
	UCVA	Near	Sph	Cyl	Axis	Add	BCVA
OD							
OS							
Patient Satisfaction (please circle)							
Very Happy 5 4 3 2 1 Unhappy							
Comments:							