



# The Eye Center of Fort Wayne

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## LASIK POST-OPERATIVE REPORT

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

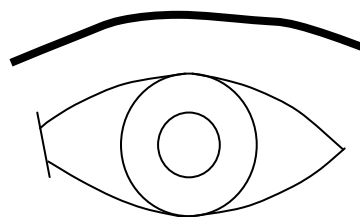
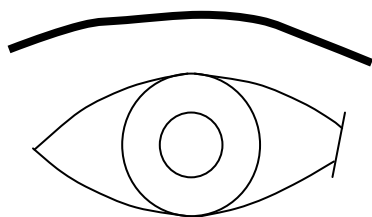
Surgery Eye: OD Date \_\_\_\_\_ Procedure \_\_\_\_\_ Surgeon \_\_\_\_\_

OS Date \_\_\_\_\_ Procedure \_\_\_\_\_ Surgeon \_\_\_\_\_

Post-op Exam: Week - 1 2 3 Month - 1 2 3 4 5 6 12

Preoperative Rx: OD \_\_\_\_\_ Refractive Goal: OD - Plano - Mono

OS \_\_\_\_\_ OS - Plano - Mono



**VA without Correction**

OD Distance \_\_\_\_\_ Near \_\_\_\_\_

OS Distance \_\_\_\_\_ Near \_\_\_\_\_

**Refraction**

OD \_\_\_\_\_ 20/

OS \_\_\_\_\_ 20/

**Keratometry:**

OD \_\_\_\_\_

OS \_\_\_\_\_

**IOP: (after one week)**

OD \_\_\_\_\_

OS \_\_\_\_\_

**Slit Lamp:**

OD \_\_\_\_\_

OS \_\_\_\_\_

1. Medications: \_\_\_\_\_

2. Comments: \_\_\_\_\_

3. Follow-up date \_\_\_\_\_

with Dr. \_\_\_\_\_

Signature of examining doctor X \_\_\_\_\_