



The Eye Center of Fort Wayne

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CATARACT SURGERY POST-OPERATIVE REPORT

Patient Name _____ Date _____

Surgery Eye: **OD** Date _____ Weeks P/O: 1 2 3 4 5 6 7 8 9 10 11
OS Date _____ Final (90 day) Other _____

Topical Injection

Additional surgical procedure _____

SUBJECTIVE

- No complaint
- Discomfort
- Flashes & Floaters
- Problem with medicine
- Other

OBJECTIVE

Distance Visual Acuity: OD 20/ _____ PH / Corrected
OS 20/ _____ PH / Corrected

Near Visual Acuity: OD J _____ 20/ _____
OS J _____ 20/ _____

Auto/Man refraction: OD _____ 20/
OS _____ 20/

IOP: OD _____ OS _____

SLIT LAMP EXAM

CONJUNCTIVA

- Normal post-op
- Injection
- Chemosis

ANTERIOR CHAMBER

- Quiet
- _____ flare, _____ cell
- Other

POSTERIOR CAPSULE

- Clear
- Cloudy
- Striae

Incision

- In tact
- Other

Pupil

- Round, reactive
- Other

Retina

- WNL
- AMD
- CME
- Other

Cornea

- Clear
- CRI
- Striae
- Other _____

Lens Implant

- Monofocal
- Multifocal
- In place
- Other _____

ASSESSMENT

- Normal healing
- Other

PLAN

1. Medication _____
2. Follow-up date _____ With Dr _____
3. Comments _____

Signature of examining doctor **X** _____

IF PAIN AND/OR DECREASE IN VISION OR VISUAL FIELD DEVELOPS, AN IMMEDIATE CONSULTATION IS INDICATED. PLEASE CALL THE EYE CENTER OF FORT WAYNE AT 260-424-5656 OR 1-800-393-7874.