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: ( ) _____

MAY 1999