RADIAL KERATOTOMY (RK)

PATIENT'S NAME: _____ FILE No._____

Date of Surgery:_____ Surgical Technique: _____

Number of treatments: _____

	UNCORRECTED ACUITY	REFRACTION & CORRECTED ACUITY	KERATOMETRY
Pre-operative data:			
OD	_____	_____ = _____	_____
OS	_____	_____ = _____	_____
3 Months Post-RK: (may be completed by an Optometrist)			
OD	_____	_____ = _____	_____
OS	_____	_____ = _____	_____
6 Months Post-RK: (may be completed by an Optometrist)			
OD	_____	_____ = _____	_____
OS	_____	_____ = _____	_____
12 Months Post-RK: (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___

Signature of attending Ophthalmologist/ Optometrist _____

Date: _____ Phone: ( ) _____

MAY 1999