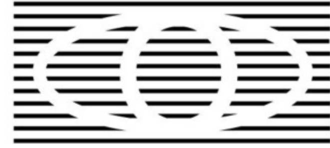

TURNER EYE INSTITUTE
MEDICAL GROUP, INC.
800-339-2733
www.turnereye.com
San Leandro San Francisco San Jose Concord

Refractive Surgery Follow Up

Assessing Dr.________________________________

Follow Up Appt. Date__________________________

Patient Name_________________________________

Surgery Date_________________________________

Post-Op Exam

OD ☐ 1 Day ☐ 1 Week ☐ 1 Month ☐ 3 Months ☐ 6 Months

OS ☐ 1 Day ☐ 1 Week ☐ 1 Month ☐ 3 Months ☐ 6 Months

History (Include comments re: fluctuating vision, glare, etc.) ________________________________

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____

____

Examination

	OD	OS
Visual Acuity without correction	____________	____________
Refraction	____________	____________
Visual Acuity with above Refraction	____________	____________
Keratometry Readings: Auto/Manual	____@____ ____@____	____@____ ____@____
Intraocular Pressure: AT or NCT	____________mm Hg	____________mmHg
Corneal Status (please check one)	________Clear	________Clear
	________Haze (circle one)	________Haze (circle one)
	Trace/Mild/Moderate/Marked	Trace/Mild/Moderate/Marked

Medications: Ocular____

Advice to Patient:____

____

Questions to Surgeon:____

____

Next Visit planned on:____

Please fax to Turner Eye Institute at
(510) 357-6330

Signed:________________________________
Assessing Doctor