HERZIG
EYE INSTITUTE

P (416) 929-2020
F (416) 929-0232

POST-OPERATIVE FORM

Date of Examination: _____ *(MM/DD/YYYY)*

Next Appointment: _____ *(MM/DD/YYYY)*

Patient Name: _____

Date of Birth: _____ *(MM/DD/YYYY)*

OD

PRK *LASIK* *OTHER* _____

_____ *days* *1 week* *1 month* *2 months*

3 months *6 months* *Other* _____

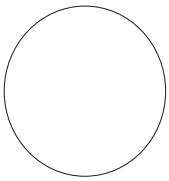
UCVA *IOP* *Haze Rating*

20/ _____ _____ _____

M _____ _____ *X* _____ *20/*
C

K _____ / _____ *X* _____

Slit Lamp Exam



Medication: _____

Comments: _____

_____

OS

PRK *LASIK* *OTHER* _____

_____ *days* *1 week* *1 month* *2 months*

3 months *6 months* *Other* _____

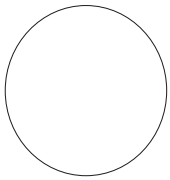
UCVA *IOP* *Haze Rating*

20/ _____ _____ _____

M _____ _____ *X* _____ *20/*
C

K _____ / _____ *X* _____

Slit Lamp Exam



Medication: _____

Comments: _____

_____

Referring Physician: _____

Address: _____

Phone #: _____ **Fax #:** _____

Email: _____