SMILE Post Procedure Care

Patient Name:____ Patient Birthdate: _________/_________/_________

Co-Managing Doctor: ____

Doctor Email: ____ Doctor Phone/Fax: ____

Procedure: ____ Procedure Date: ____

Target: OD: ☐ DISTANCE ☐ NEAR ☐ MONOVISION OS: ☐ DISTANCE ☐ NEAR ☐ MONOVISION

POST OPERATIVE EXAM AND COMMENTS

Day 3 or 4 1 Month 3 Month

MEDS: ____________________________________ QID TID BID QD // OD OS OU

MEDS: ____________________________________ QID TID BID QD // OD OS OU

MEDS: ____________________________________ QID TID BID QD // OD OS OU

UCVA: OD 20/__________ OS 20/____________ Blurry / Glare / Double / Fluctuating Vision

AUTO REFRACTION: ____

MANIFEST: DRY ____

BIOMICROSCOPY:

Adnexa: Normal Other: ____

Lids/Conj/Sclera: Normal Other: _____________________________________

Cornea: Normal Other: ____

Anterior Chamber: ____

Lens: Clear Other: ____

IOP: OD: _______________________ OS: ____________________________

Doctor Signature: ____ **Date:** ____

GCEC is committed to providing the best are and results. Please fax to (727) 823-8796