Kevin H. Cuevas, M.D.

CATARACT POST-OP REPORT FORM

PATIENTS' NAME_____DATE_____

REFERRING DOCTOR_____

CATARACT EXTRACTION DATE: OD_____OS_____

MEDICATIONS: OD_____ QID TID BID QD
_____ QID TID BID QD
OS_____ QID TID BID QD
_____ QID TID BID QD

CC/ADDITIONAL MEDS: _____

EXAMINATION OF OPERATED EYE(S)

4 week Post-op K's

POST-OP VISIT: OD: DAY ONE WEEK 1 2 3 4 5 6 7 8 9 10 11 12 _____/_____@_____
OS: DAY ONE WEEK 1 2 3 4 5 6 7 8 9 10 11 12 _____/_____@_____

VA SC OD: 20/_____ PH: 20/_____ OS: 20/_____ PH: 20/_____

MANIFEST REFRACTION OD: _____ VA: 20/_____
OS: _____ VA: 20/_____

SLIT LAMP EXAM (CIRCLE WITH COMMENTS)

WOUND/SUTURES OD: INTACT_____ SEIDEL_____
OS: INTACT_____ SEIDEL_____

CORNEA OD: CLEAR STRIAE_____EDEMA_____
OS: CLEAR STRIAE_____EDEMA_____

A/C OD: CLEAR 1+ 2+ 3+ 4+ CELL/FLARE
OS: CLEAR 1+ 2+ 3+ 4+ CELL/FLARE

IOL OD: CENTERED_____DECENTERED_____
OS: CENTERED_____DECENTERED_____

POST.CAPSULE OD: CLEAR HAZY_____WRINKLED_____
OS: CLEAR HAZY_____WRINKLED_____

MACULA OD: WNL CME_____AMD_____OTHER_____
OS: WNL CME_____AMD_____OTHER_____

FUNDUS _____

TENSIONS (APPLANATION/NCT) OD:_____OS:_____mmHg@_____AM/PM

IMPRESSION/PLAN_____
_____
_____
_____

Signature:_____

****Immediate consultation indicated for any severe pain and/or decrease in vision****