POSTOPERATIVE EXAM FORM

Patient _____

Date _____

Weeks Postop. 3 4 5 6 Final
(circle week)

Referring Doctor _____
(Please Print)

Referring Doctor's
Signature _____

WOUND	ANT. CHAMBER	LENS IMPLANT	TONOMETRY	REFRACTION	RETINA
Well Closed _____	DEEP	CENTERED _____	BY APPLANATION	OPERATIVE EYE:	NORMAL _____
Other _____	&	Sketch if not			if not normal
_____	QUIET _____	Centered	_____ mmHg	_____	please ✓ below
_____	if not, please ✓ below				
_____	CELLS			VA: _____	CME _____
CORNEA	1+ Few _____				Other _____
	2+ Mild _____	POSTERIOR CAPSULE			
CLEAR _____	3+ Mod. _____	FIBROSIS	COMMENTS:		
If not, please ✓ below	4+ Severe _____	1+ _____			
Stromal Edema 1+ _____	FLARE	2+ _____			
2+ _____	1+ _____	3+ _____			
3+ _____	2+ _____	4+ _____			
4+ _____	3+ _____				
	4+ _____				