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Cataract Post Operative Outcomes Document

Patient Name: _____ Date of Birth _____ Surgeon: _____

Date of Exam: _____ Hospital: _____ Surgery Date: **OD** _____ **OS** _____

Time since surgery: (please circle) **OD** _____ day(s) week(s) **OS** _____ day(s) week(s)

Current Spectacle Rx: **OD** _____ Auto refraction: **OD** _____

OS _____

OS _____

Meds: **OD** Ofloxacin: QID completed (PLEASE CIRCLE) **OS**: Ofloxacin: QID completed (PLEASE CIRCLE)
 Prednisolone: QID TID BID qd completed Prednisolone: QID TID BID qd completed
 Tri-Moxi at time of surgery Tri-Moxi at time of surgery
 Other: _____ Other: _____

IOL: (please circle one) TRADITIONAL/ MONO SYMFONY/ TECNIS MF TORIC/ SYMFONY TORIC

Patient Satisfaction: (0-5) _____ Night Vision: (please circle) Same Better Worse

Complaints: _____

VAsc **OD** _____ **PH** _____ **MR** **OD** _____ **VA** _____ / _____

OS _____ **PH** _____ **OS** _____ **VA** _____ / _____

OD

OS

IOP:

Wound: secure secure _____

Cornea: clear clear _____

A.C.: deep deep _____

IOL: centered centered _____

Other exam: _____

Assessment: Pseudophakia **OD** **OS** **OU** _____

Plan: _____

Return to clinic: _____ Signature: _____ O.D.