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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) TRADITONAL/ MONO SYMFONY/ TECNIS MF TORIC/ SYMFONY TORIC

Patient Satisfaction: (0-5) _____ Night Vison: (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.