SURGERY POST-OP REPORT
*ATTN: SURGERY SCHEDULING*
☎ 414.977.3375
414.272.3932

MILWAUKEE EYE CARE
EST. 1933

PATIENT NAME: _____ DOB: _____

REFERRING OD: _____ LOCATION: _____

○ Jason N. Edmonds, MD ○ Peter S. Foote, MD ○ Nicholas J. Frame, MD ○ Mackenzie M. Sward, MD

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**OPERATED EYE / SURGERY DATE: OD:** _____ **OS:** _____

Today's Post-Op Visit Date: _____ is Post-Op Visit # ○ 1 ○ 2 ○ 3

**POST-OP EXAM FINDINGS**

**Cornea**

| | | | | | |
|---|---|---|---|---|---|
| Striae | neg | +1 | +2 | +3 | +4 |
| Edema | neg | +1 | +2 | +3 | +4 |

**Anterior Chamber**

| | | | | | |
|---|---|---|---|---|---|
| Depth | | +1 | +2 | +3 | +4 |
| Hypopyon | neg | +1 | +2 | +3 | +4 |
| Blood in Chamber | neg | +1 | +2 | +3 | +4 |
| Cells & Flare | neg | +1 | +2 | +3 | +4 |

| | | |
|---|---|---|
| Pupil | □ round | □ irregular |
| Seidel Negative | □ yes | □ no |
| Posterior Capsule | □ clear | □ hazy |
| Implant Position | □ centered | □ decentered |

**Dilated Fundus Exam Results**

| | | |
|---|---|---|
| Attached | □ yes | □ no |
| Macular Edema | □ yes | □ no |

**Uncorrected VA:** Distance 20 / _____ Near 20 / _____ **IOP:** OD_____ OS_____

| Refraction | |
|---|---|
| OD _____ | 20 / _____ |
| OS _____ | 20 / _____ |

**Comments:**

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