

# DreamLens Follow-Up Form

**Patient Information**

	Sph	Cyl	Axis	Target	Flat K	Steep K	"e" Val	Problems/Comments	
OD									
OS									

Time Inserted

Time Removed

Hours Worn

Avg Hours Worn

Visit Type

Vision Quality
Today
During Day
At Night

UCVA    With  
          Lenses

**OD**

**OS**

**OU**

		Refraction without Lenses			
20/	20/				20/
20/	20/				20/
20/	20/	Refraction with Lenses			
		<b>OD</b>			
					20/
		<b>OS</b>			
					20/

Slit Lamp OD

Slit Lamp OS

Next Visit

Conclusion