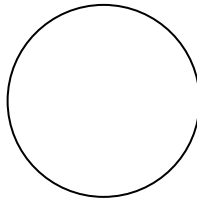
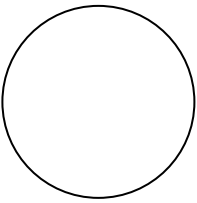


<p><b>PATIENT NAME</b> _____</p> <p><b>DOB</b> _____ <b>PROCEDURE DATE</b> _____</p> <p><b>OPTOMETRIST</b> _____</p> <p><b>SURGEON</b> _____</p>	<p><b>PRESENT MEDICATIONS</b>      <b>OD</b>      <b>OS</b></p> <p><input type="checkbox"/> <b>NO MEDS</b></p> <p><input type="checkbox"/> <b>BCL</b> _____</p> <p><input type="checkbox"/> <b>PRED-MOXI COMBO</b> _____</p> <p><input type="checkbox"/> <b>ANTIBIOTIC</b> _____</p> <p><input type="checkbox"/> <b>STEROID</b> _____</p> <p><input type="checkbox"/> <b>NSAID</b> _____</p> <p><input type="checkbox"/> <b>ARTIFICIAL TEARS</b> _____</p> <p><input type="checkbox"/> <b>OTHER</b> _____</p>																																																					
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