

Patient's Name: \_\_\_\_\_

SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Student: \_\_\_\_\_ Attending: \_\_\_\_\_

Insurance: \_\_\_\_\_



Date: \_\_\_\_\_

**Subjective Data**

Chief Complaint/Reason for Visit: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Contact Lens Services Today: Refer to CL form

**History of Present Illness**

Location:  
Quality:  
Severity:  
Duration:  
Timing:  
Context:  
Modifying factors:  
Associated signs or symptoms:

**Review of Symptoms**

Primary ROS taken today  
 Reviewed \_\_\_ / \_\_\_ / \_\_\_ ROS today:  
Changes: \_\_\_\_\_

**Past, Family & Social History**

Past: Ocular:  
      Medical:  
Family: Ocular:  
      Medical:  
Social/Occupational:  
Medications:

**Attending Notes**

Chief Complaint/Reason for Visit: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Objective Data**

DVA SC CC CL  
OD 20/\_\_\_ PH 20/\_\_\_  
OS 20/\_\_\_ PH 20/\_\_\_  
OU 20/\_\_\_

NVA SC CC CL  
OD 20/\_\_\_  
OS 20/\_\_\_  
OU 20/\_\_\_

Habitual Rx1  
OD \_\_\_\_\_  
OS \_\_\_\_\_  
Add \_\_\_\_\_ Prism \_\_\_\_\_

Habitual Rx2  
OD \_\_\_\_\_  
OS \_\_\_\_\_  
Add \_\_\_\_\_ Prism \_\_\_\_\_

Cover Test SC CC \_\_\_\_\_ distance  
                  SC CC \_\_\_\_\_ near

Color Vision SC CC \_\_\_\_\_ OD  
Method: \_\_\_\_\_ OS

Stereo SC CC \_\_\_\_\_  
Method: \_\_\_\_\_

Acc Amps SC CC  
                                  \_\_\_\_\_ OD  
                                  \_\_\_\_\_ OS

NPC \_\_\_\_\_ / \_\_\_\_\_

Pupils \_\_\_\_\_

EOMs \_\_\_\_\_

FCFs \_\_\_\_\_ OD  
                                  \_\_\_\_\_ OS

**Attending Notes**

EOMs \_\_\_\_\_

Pupils \_\_\_\_\_

FCFs \_\_\_\_\_ OD  
                                  \_\_\_\_\_ OS

## REFRACTIVE TESTING

Keratometry OD \_\_\_\_\_ / \_\_\_\_\_ @ \_\_\_\_\_ mires \_\_\_\_\_  
OS \_\_\_\_\_ / \_\_\_\_\_ @ \_\_\_\_\_ mires \_\_\_\_\_

Retinoscopy OD \_\_\_\_\_ 20/  
OS \_\_\_\_\_ 20/

Subjective Refraction OD \_\_\_\_\_ 20/  
OS \_\_\_\_\_ 20/

Binocular Balance OD \_\_\_\_\_ 20/                      20/  
OS \_\_\_\_\_ 20/

Trial Frame OD \_\_\_\_\_ 20/                      20/  
OS \_\_\_\_\_ 20/                      20/  
                  \_\_\_\_\_ add

## Attending Notes

## BINOCULAR TESTING

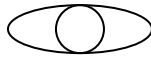
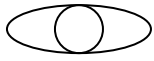
## ADDITIONAL PROCEDURES

**OCULAR HEALTH ASSESSMENT**

OD

BIOMICROSCOPY

OS



lids/adnexa  
 Cornea  
 Conj/sclera  
 Iris  
 AC  
 Lens  
 Vitreous  
 angles

**Attending Notes**

lids/adnexa  
 Cornea  
 Conj/sclera  
 Iris  
 AC  
 Lens  
 Vitreous  
 angles

**Additional Ocular Health Testing Procedures:**

**TONOMETRY**  GAT  NCT  Other \_\_\_\_\_  
 OD \_\_\_\_\_ OS \_\_\_\_\_ @ \_\_\_\_\_ AM / PM

**OPHTHALMOSCOPY**  
 Dilated?  Yes  No  
 With \_\_\_\_\_ gtt of \_\_\_\_\_

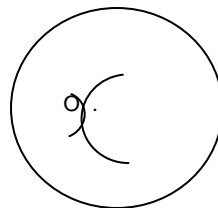
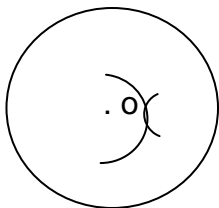
Dilation warning given?  Yes  No

**FUNDUS EXAM**  
 Direct  78D  90D  SF  Indirect  Other \_\_\_\_\_

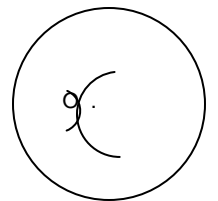
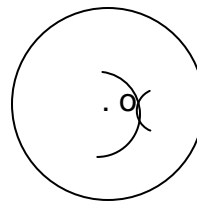
Disk

cup/disk  
 margins  
 rims  
 a/v  
 macula  
 fovea  
 periphery

Disk



cup/disk  
 margins  
 rims  
 a/v  
 macula  
 fovea  
 periphery



**Additional Testing / Procedures**

**Attending Notes**

**Attending's Assessment and Treatment Plan**

**Assessment:**

**Plan:**

**Next recommended appointment:** \_\_\_\_\_

<b>Final Rx</b>		
<b>OD</b> _____		<b>Add</b> _____
<b>OS</b> _____		<b>Add</b> _____

This is to confirm that I met with this patient, reviewed reason(s) for visit and health history, reviewed and personally performed or repeated all clinical procedures if required by Medicare or other third party payors, verified the ocular health of the patient, determined the diagnosis and prescribed the above treatment.

**Attending's Signature / Degree:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Student's Assessment and Recommended Treatment Plan

**Assessment:**

**Plan:**

**Student's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_