

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

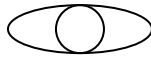
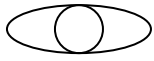
ADDITIONAL PROCEDURES

OCULAR HEALTH ASSESSMENT

OD

BIOMICROSCOPY

OS



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

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

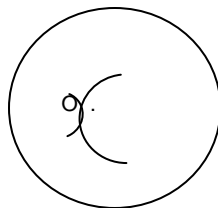
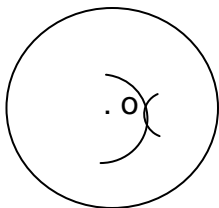
FUNDUS EXAM

Direct 78D 90D SF Indirect Other _____

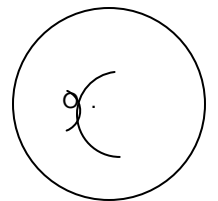
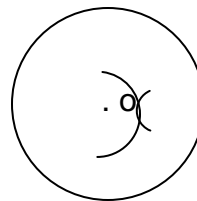
Disk

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: _____

Final Rx		
OD _____		Add _____
OS _____		Add _____

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: _____