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:

Objective Data

DVA SC CC CL
OD 20/___ PH 20/___
OS 20/___ PH 20/___
OU 20/___

Habitual Rx1
OD ____________________________
OS ____________________________
Add ________ Prism ________

Cover Test SC CC ___ distance
SC CC ___ near

Stereo SC CC ____________________________
Method: ____________________________
NPC _____ / _______
EOMs ____________________________

NVA SC CC CL
OD 20/___
OS 20/___
OU 20/___

Habitual Rx2
OD ____________________________
OS ____________________________
Add ________ Prism ________

Color Vision SC CC _______ OD
Method: _______ _______ OS

Acc Amps SC CC
OD ____________________________
OS ____________________________
Pupils ____________________________

EOMs ____________________________

Attending Notes

Chief Complaint/Reason for Visit: ________
________________________________________________________________________
________________________________________________________________________

EOMs ____________________________

Pupils ____________________________

FCFs ____________________________ OD
__________________________ OS
### REFRACTIVE TESTING

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<th>Procedure</th>
<th>OD</th>
<th>OS</th>
</tr>
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<tr>
<td>Keratometry</td>
<td>______ / _____ @ ______ mires ______</td>
<td>______ / _____ @ ______ mires ______</td>
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<tr>
<td>Retinoscopy</td>
<td>OD ____________ 20/</td>
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<td>Subjective Refraction</td>
<td>OD ____________ 20/</td>
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<td>Binocular Balance</td>
<td>OD ____________ 20/</td>
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<td>Trial Frame</td>
<td>OD ____________ 20/</td>
<td>OS ____________ 20/</td>
</tr>
<tr>
<td></td>
<td>______ add</td>
<td></td>
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</tbody>
</table>

### BINOCULAR TESTING

### ADDITIONAL PROCEDURES
OCULAR HEALTH ASSESSMENT

OD   BIOMICROSCOPY   OS

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 _____________

cup/disk margins
rims
a/v
macula
fovea
periphery

Disk                                  Disk   a/v
macula
fovea
periphery
Attending Notes

Additional Testing / Procedures

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: ________________