

Patient Name _____ Social Security _____
 Address _____ Date _____
 City _____ Zip _____ Date of Birth _____ Age _____
 Occupation _____ Home Phone _____
 Guardian Name _____ Office Phone _____
 Guardian Social Security _____ Date of last eye exam _____
 E-mail Address: _____ Previous Eye Doctor's Name: _____

MEDICAL HISTORY (CHECK APPROPRIATE BOXES) REASONS FOR EXAM DOCTOR'S COMMENTS

	Family	Patient	Blur at distance	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Blur at near	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Eye burning, itching	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Redness	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>	Check-up	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Contact Lenses	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>
Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	LASIK (considering)	<input type="checkbox"/>
Drugs/Alcohol/Tobacco	<input type="checkbox"/>	<input type="checkbox"/>		

Are you taking any medication? _____ If so, which ones? _____
 Do you have any allergies, medical or otherwise? _____ if so, to what? _____
 Hobbies, interests, special visual requirements? _____
 Were you referred here by someone? _____ If so, by whom? Doctor Relative Friend Newspaper Ad Other _____
 Yellow Pages Direct Mail Sign
 How is payment to be made: Cash Check Visa/Mastercard Medicaid Medicare _____
 Signature _____

	SPH	CYL	X	A	Add	BC	P.D.
Present	OD						
RX	OS						

K's OD _____ @ _____ @ _____
 OS _____ @ _____ @ _____

VA/S	without RX		with RX	
	Far	Near	Far	Near
	OD 20/	20/	OD 20/	20/
	OS 20/	20/	OS 20/	20/
	OU 20/	20/	OU 20/	20/
	Pinhole			

Pupil Responses: PERRLA _____
 CT: Far ⊕ ⊕ ⊕ _____
 Near ⊕ ⊕ ⊕ _____
 Versions: smooth & full
 NPC: _____ cm Accom: OD _____ D OS _____ D OU _____ D
 Visual Field _____ NRA _____ PRA _____

Retinoscopy _____ Cycloplegic _____ Final RX _____

	SPH	CYL	X	A	Add	BC	P.D.
OD							
OS							

VA 20/ _____
 VA 20/ _____
 Comments: _____

Retinoscopy _____ Cycloplegic _____ Final RX _____

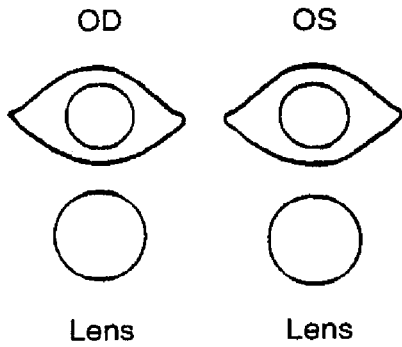
	SPH	CYL	X	A	Add	BC	P.D.
OD							
OS							

VA 20/ _____
 VA 20/ _____
 Comments: _____

Color Test: Pass Fail Diagnosis _____ Stereo: Pass / Fail _____

Other Tests: _____

SLIT LAMP EXAM*



OD	OS	_____ Lashes _____
		_____ Lids _____
		_____ Sciera _____
		_____ Cornea _____
		_____ Ant Cham _____
		_____ IV III II I Angle I II III IV _____
		_____ Iris _____
		_____ Lens _____

Tonometry

OD	OS	
_____	_____	
NCT	Goldmann	Manual Palpitations
Time _____		

*all structures considered normal unless otherwise noted

INTERNAL undilated dilated

OD	OS	
_____ C/D _____		
1 2/3 1/2 1/3 A/V 1/3 1/2 2/3 1		
_____ 3/4 1/2 1/4 ALR 1/4 1/2 3/4 _____		
- dim + FR + dim -		
_____ WNL Vessels WNL _____		
_____ WNL Crossings WNL _____		
_____ WNL Macula WNL _____		

Drugs used: _____ drops Flouress OD OS OU

_____ drops _____ % proparacaine OD OS OU

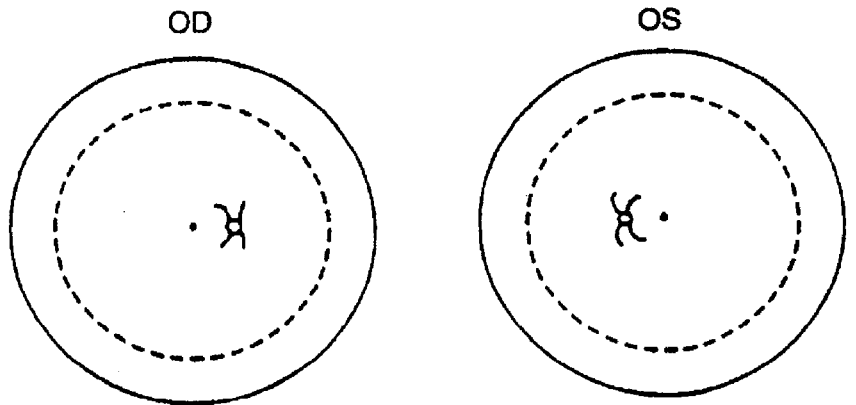
_____ drops _____ % tropicamide OD OS OU

_____ drops _____ % cyclopentolate OD OS OU

_____ drops _____ % phenylephrine OD OS OU

_____ drops _____ % _____ OD OS OU

Other Pertinent Info:



Dx:

P:

Return to Office _____ Doctor _____