

Examination

Patient: _____ Sex: M F DOB: _____ Last Exam: _____ Date: _____

Chief Complaint: _____

Consult? yes no Consultation Requested by: _____

HISTORY

HPI: •Symptoms: •Location: •Quality: •Severity: •Duration: •Timing: •Context: •Modifiers:	•Allergies: •Medications: •Ocular ROS: •Medical History & ROS from _____ / _____ / _____ reviewed: <input type="checkbox"/> no changes (Date) _____ (Dr. Initials) _____
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EXAMINATION

• Head/Face <input type="checkbox"/> nl	• Psych: Mood/Affect (anxiety/agitation/depression) <input type="checkbox"/> nl	• Neuro: Oriented (person/time/place) <input type="checkbox"/> y <input type="checkbox"/> n
VA sc< cc< ph< near glare<		
K: OD _____ OS _____	OD RX: OD _____ OS _____	add _____ add _____
A-Scan: OD _____ OS _____	REF: OD _____ OS _____	20/ _____ add _____ 20/ _____ add _____
CVF: <input type="checkbox"/> nl	MOTILITY: <input type="checkbox"/> Full	COVER TEST: <input type="checkbox"/> Eso _____ <input type="checkbox"/> Exo _____ <input type="checkbox"/> Ortho
	ADNEXA/ EYELIDS: <input type="checkbox"/> nl	<input type="checkbox"/> Blepharitis OD OS OU <input type="checkbox"/> Meibomianitis OD OS OU
PUPILS: <input type="checkbox"/> no afferent defect <input type="checkbox"/> round OU	Size: OD _____ OS _____	<input type="checkbox"/> Indent <input type="checkbox"/> 14D <input type="checkbox"/> 20D <input type="checkbox"/> 28D <input type="checkbox"/> 78D <input type="checkbox"/> 90D <input type="checkbox"/> 3 Mirror <input type="checkbox"/>
SLE: <input type="checkbox"/> nl <input type="checkbox"/> FBUT: _____ <input type="checkbox"/> nl <input type="checkbox"/> arcus <input type="checkbox"/> nl <input type="checkbox"/> pterygium <input type="checkbox"/> nl <input type="checkbox"/> injection <input type="checkbox"/> nl <input type="checkbox"/> pinguecula <input type="checkbox"/> D&Q <input type="checkbox"/> rubeosis <input type="checkbox"/> clear	TEAR FILM <input type="checkbox"/> nl <input type="checkbox"/> FBUT: _____ CORNEA <input type="checkbox"/> nl <input type="checkbox"/> arcus <input type="checkbox"/> nl <input type="checkbox"/> pterygium SCLERA <input type="checkbox"/> nl <input type="checkbox"/> injection CONJ. <input type="checkbox"/> nl <input type="checkbox"/> pinguecula AC <input type="checkbox"/> D&Q <input type="checkbox"/> IRIS <input type="checkbox"/> nl <input type="checkbox"/> rubeosis LENS <input type="checkbox"/> clear <input type="checkbox"/>	RETINA: OD <input type="checkbox"/> nl <input type="checkbox"/> drusen <input type="checkbox"/> nl <input type="checkbox"/> RPE chngs <input type="checkbox"/> nl <input type="checkbox"/> <input type="checkbox"/> nl <input type="checkbox"/> PVD <input type="checkbox"/> nl <input type="checkbox"/>
	MACULA <input type="checkbox"/> nl <input type="checkbox"/> drusen <input type="checkbox"/> nl <input type="checkbox"/> RPE chngs	VESSELS <input type="checkbox"/> nl <input type="checkbox"/> VITREOUS <input type="checkbox"/> nl <input type="checkbox"/> PVD PERIPHERY <input type="checkbox"/> nl <input type="checkbox"/>
	OPTIC DISCS: OD <input type="checkbox"/> nl SIZE/APPEARANCE/NFL <input type="checkbox"/> _____ C/D	OS <input type="checkbox"/> nl <input type="checkbox"/> _____
T / @ _____ (Method)	Pachymetry: OD _____ OS _____	Dilated: M .5% 1% C 1% 2% N 2.5% 10% OU @ _____

DIAGNOSIS / PLAN

RTO:

DR. _____