EYE EXAMINATION

Patient Name _____ DOB _____ Date _____

Chart # _____ Provider _____ ☐ New Pt ☐ Est Pt

CHIEF COMPLAINT / HPI

_____

_____

_____

HISTORY

Ocular Hx	Medical Hx	Meds	Allergies	Family Hx

ENTRANCE TESTING

VA	DISTANCE			NEAR	
	sc	cc	ph	sc	cc
OD					
OS					
OU					

Cover Test: D _____ N _____ (prism / direction)

Pupils: PERRLA ☐ (-) APD ☐ APD: OD ☐ OS ☐

EOM: full ☐ restricted ☐ _____

CVF: FTFC ☐ OD _____ OS _____

Stereo: _____ sec of arc

Color: OD _____ OS _____

IOP / PACHYMETRY

Method: ☐ GAT ☐ NCT ☐ iCare **Time:** _____ **IOP:** OD _____ OS _____ mmHg **Pachy:** OD _____ OS _____ µm

EYE DROPS INSTILLED

☐ Proparacaine ☐ Fluorescein ☐ Tropicamide 0.5% ☐ Tropicamide 1% ☐ Phenylephrine 2.5% ☐ Cyclopentolate 1% **Other:** _____ **Time:** _____

Dilation: ☐ deferred ☐ risks & benefits of dilating discussed with patient

REFRACTION

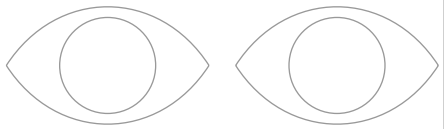
Keratometry: OD _____ @ _____ / _____ @ _____ OS _____ @ _____ / _____ @ _____

	OD			OS		
	Sphere / Cyl / Axis	Add	VA	Sphere / Cyl / Axis	Add	VA
Habitual Rx						
Autorefraction						
Retinoscopy						
Cycloplegic						
Manifest			D N			D N
Final Rx						

ANTERIOR SEGMENT (SLIT LAMP)

Normal ☐

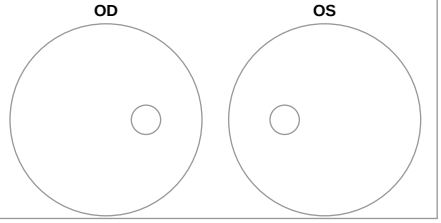
	OD	OS
Lids / Lashes		
Conjunctiva		
Cornea		
Ant. Chamber		
Iris		
Lens		



POSTERIOR SEGMENT (DFE)

Normal ☐

	OD	OS
C/D Ratio		
Disc		
Macula		
Vessels		
Periphery		



ASSESSMENT & PLAN

_____

_____

RTC: _____ **Signature:** _____ **Date:** _____

CONTACT LENS EVALUATION

CONTACT LENS HISTORY

Current Lenses (brand / Rx)	Modality / Wear Time	Solutions / Care	Comfort / Complaints

TRIAL LENSES / OVER-REFRACTION

#		Power (Sph / Cyl / Axis)	Brand / BC / Diam	VA	Over-Refraction	OR VA
1	OD					
	OS					
Comments / Fit:						
2	OD					
	OS					
Comments / Fit:						
3	OD					
	OS					
Comments / Fit:						

FINAL CONTACT LENS Rx

	Power (Sph / Cyl / Axis)	Brand / BC / Diam	Add	Supply / Replacement
OD				
OS				

DISPENSING / CARE

Wear Schedule: _____ **Replacement:** _____ **Care System:** _____

I&R Training: ☐ completed ☐ scheduled ☐ n/a **Dispensed:** ☐ trial lenses ☐ Rx lenses **CL Rx released:** ☐

ASSESSMENT & PLAN

_____

_____

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RTC: _____ **Signature:** _____ **Date:** _____