***Patient***:

* PatientID – Unique id of patient
* Gender – Gender of patient, either male or female
* FirstName – First name of patient
* LastName – Last name of patient
* DOB – Date of birth of patient
* Phone – Phone number of patient

***Record***:

* RecordID – Unique id of a patient’s record
* AppointmentID – Id of the appointment, references AppointmentID in the Appointment table
* RecommendationID – Id of the recommendation, references RecommendationID in the Recommendation table
* UpdatedByStaff – Id of the staff who entered the record, references StaffID in the Staff table
* FamiliarityWithCondition – Patient’s familiarity with condition (low, med, high)
* ReasonForVisit – Patient’s listed reason(s) for visiting (consultation, follow-up, new consultation, post-op)
* ReasonForConsultation – Patient’s listed reason for consultation

***Appointment***:

* AppointmentID – Unique id of an appointment
* PatientID – Id of the patient, references PatientID in the Patient table
* Date – Date of the appointment
* Time – Start time of the appointment
* EndTime – End time of the appointment
* ExamRoom – Assigned exam room of the appointment

***Staff***:

* StaffID – Unique id of staff
* FirstName – First name of staff
* LastName – Last name of staff
* Position – Position of staff
* Phone – Phone number of staff
* Email – Email of staff
* Schedule – Schedule of staff

***AppointmentStaff***:

* AppointmentStaffID – Unique id of appointment’s staff
* AppointmentID – Id of appointment, references AppointmentID in the Appointment table
* StaffID – Id of staff, references StaffID in the Staff table

***MedicalCondition***:

* MedicalConditionID – Unique id of patient’s medical condition
* RecordID – Id of record, references RecordID in Record table
* Condition – Medical condition of the patient
* Duration – Length of time the condition was experienced by patient

***Biopsy***:

* BiopsyID – Unique id of biopsy
* RecordID – Id of record, references RecordID in Record table
* Biopsy – Site of biopsy (eye lash, conjunctivitis, anterior sheath, tear duct, cornea, iris, pupil)

***Recommendation***:

* RecommendationID – Unique id of recommendation
* RecordID – Id of record, references RecordID in Record table
* Recommendation – Recommended course of action

***FamilyHistory***:

* FamilyHistoryID – Unique id of family history
* RecordID – Id of record, references RecordID in Record table
* Condition – Medical condition of patient’s family

***Billable***:

* BillableID – Unique id of billable item
* RecordID – Id of record, references RecordID in Record table
* BillableItem – Billable item
* Price – Cost of billable item

Stuff to ask optometrist:

General procedures once a patient fills out a form, sees an optometrist, and all stages beyond

Ex. If a biopsy is conducted, what are timeframes for testing and informing patient of diagnosis? Are follow-up appointments usually necessary? Is there a standard recommended course of action for different medical conditions?

Sample/examples of medical forms will allow us to get an idea of the variations of everyone’s answers.

List of conditions/symptoms/anything on the form where there are checkboxes