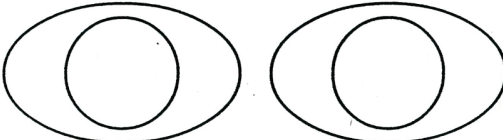
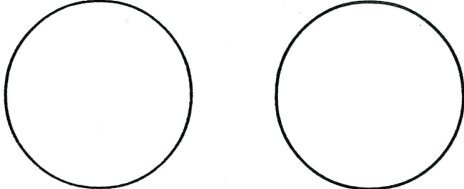


CHIEF COMPLAINT _____

HISTORY

HPI: <ul style="list-style-type: none"> • Symptoms: • Location: • Quality: • Severity: • Duration: • Timing: • Context: • Modifiers: 	<ul style="list-style-type: none"> • Allergies: • Medications: • Ocular ROS: • Medical History & ROS from ____/____/____ reviewed: <input type="checkbox"/> no changes <div style="text-align: right;"> <div>(Date)</div> <div>(OD Initials)</div> </div>
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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 _____	OLD RX:	OD _____ OS _____	add _____ add _____	
		REF:	OD _____ 20/ OS _____ 20/	add _____ add _____	
CVF:	<input type="checkbox"/> nl	ADNEXA / EYELIDS: <input type="checkbox"/> nl <input type="checkbox"/> Blepharitis OD OS OU <input type="checkbox"/> Meibomianitis OD OS OU			
MOTILITY:	<input type="checkbox"/> Full				
COVER TEST:	<input type="checkbox"/> Eso _____ <input type="checkbox"/> Exo _____				
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"/> 28D <input type="checkbox"/> 78D <input type="checkbox"/> 90D <input type="checkbox"/> 3 Mirror <input type="checkbox"/> 20D		
					
					
SLE:	OD	OS	RETINA:	OD	OS
<input type="checkbox"/> nl <input type="checkbox"/> FBUT: _____	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 <input type="checkbox"/> nl <input type="checkbox"/> SCLERA <input type="checkbox"/> nl <input type="checkbox"/> CONJ. <input type="checkbox"/> nl <input type="checkbox"/> injection <input type="checkbox"/> nl <input type="checkbox"/> pinguecula <input type="checkbox"/> D&Q <input type="checkbox"/> <input type="checkbox"/> nl <input type="checkbox"/> rubeosis <input type="checkbox"/> clear <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"/>	<input type="checkbox"/> nl <input type="checkbox"/> drusen		
<input type="checkbox"/> nl <input type="checkbox"/> arcus _____			<input type="checkbox"/> nl <input type="checkbox"/> RPE chngs		
<input type="checkbox"/> nl <input type="checkbox"/> pterygium			<input type="checkbox"/> nl <input type="checkbox"/>		
<input type="checkbox"/> nl <input type="checkbox"/>			<input type="checkbox"/> nl <input type="checkbox"/> PVD		
<input type="checkbox"/> nl <input type="checkbox"/> injection			<input type="checkbox"/> nl <input type="checkbox"/>		
<input type="checkbox"/> nl <input type="checkbox"/> pinguecula					
<input type="checkbox"/> D&Q <input type="checkbox"/>					
<input type="checkbox"/> nl <input type="checkbox"/> rubeosis					
<input type="checkbox"/> clear <input type="checkbox"/>					
			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"/>				
			OPTIC DISCS:	OD	OS
			<input type="checkbox"/> nl	SIZE/APPEARANCE/NFL	<input type="checkbox"/> nl
			<input type="checkbox"/> _____	C/D _____	<input type="checkbox"/> _____

DIAGNOSIS / PLAN	MDM	1	2	3	4
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Order: ☐ HRT/GDX/OCT RTO: _____ day
☐ Photo _____ week
☐ VF _____ month
☐ Consult _____ year

Dr. _____