

Medical Records For : Scanlon, Graham
Date of Birth : 05/22/1999
Date of Service : 07/29/2024
Electronically signed by : Dr. Schwalb, OD, Lauren 07/29/2024
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Technician: Patti Jackson

PRE TEST

Prescribed Date - Medication Name - Status - Form
05/30/2024 - Ritalin - Active -

Status - Allergy Agent - Reaction - Severity
- Empty List - -

No current medications

X

School _____ Grade _____ Occupation _____ Web Developer _____

Hobbies Reading, Outdoors and Music

Referral			Accompanied by			
Visual Acuity Method	Type of Chart	Age of Glasses	03/24	Prism		
Type of Correction		Hab Rx OD:	-2.50	-1.00	180	
Unaided Visual Acuity Dist	Near	Hab Rx OS:	-3.00	sph		
sc OD: 20/	sc OD: 20/	Add:	Sync III 9			
sc OS: 20/	sc OS: 20/	Style				
sc OU: 20/	sc OU: 20/	Hab Rx 2 OD:				Prism
Acuity with Glasses Dist	Near	Hab Rx 2 OS:				
cc OD: 20/20	cc OD: 20/ 25-1	Add:				
cc OS: 20/ 20	cc OS: 20/ 25	Style				
cc OU: 20/20	cc OU: 20/ 20/2	Hab Rx 3 OD:				Prism
Acuity with Contacts Dist	Near	Hab Rx 3 OS:				
cc OD: 20/	cc OD: 20/	Add:				
cc OS: 20/	cc OS: 20/	Style				
cc OU: 20/	cc OU: 20/	Series				BC
AR OD: -2.50	-1.25	007	CL Rx OD:			
AR OS: -3.00	-0.25	034	CL Rx OS:			
Pupillary Distance		Sph	Cyl	Axis	Add	
OD PD				X		
OS PD					X	
Binoc						

King Devick			VF Screening:	
Test I	Stereo:		OD	
Test II	Fly	+	OS	
Test III	Age Expected	Animals	3/3	
Total Time		Wirt Circles	5/10	Color Vision:
		Randot Circles	4/8	IOP 1
Errors I		Randot Large Shapes	8/8	Tonometry OD:
Errors II		Dinosaur		Tonometry OS:
Errors III	Age Expected			Method:
Total Time		Fixation Disparity	slightly exo / 0	Time:
		Trial Frame		Time:

Addendum:

Reason for exam today:

BV FU

Family Eye Doctor: Last Eye Exam: 2024

If not your family eye doctor, whom can we thank for the referral? Dr. Tonya Bourn

CHIEF COMPLAINT

bv follow up

Location: ou

Severity:

Quality:

Duration:

Timing:

Context: skipped 3 weeks of hvt, but was able to pick it back up and noticed improvement.

Secondary Complaints:

NOTES: potential b9 or b12 deficiency. - has gene mutations that potentially deplete b9 and b12

REVIEW OF OCULAR SYSTEM:

Any history of the following?

Strabismus Amblyopia Cataracts Eye trauma Glaucoma Macular Degeneration

Have you ever had eye surgery? If so, please list type of surgery and date(s):

Do you wear glasses or contacts? Yes No

Have you ever been prescribed glasses or contacts? Yes No

Eye Meds:

Last Eye Exam:

Doctor:

PREVIOUS VISION CORRECTION

Primary Vision Correction:

Back up specs?

Planning to get new glasses?

Type of CLs worn in past:

Wear Time:

Cleaner:

Disposal:

Mental Assessment

Time, Place, Person
oriented

Mood and Affect
normal

Addendum:

For Children: Mother's Name: Father's Name:

THE FOLLOWING QUESTIONS ARE TO BE ANSWERED BY BOTH ADULT AND CHILDREN PATIENTS

Family Eye Doctor: Last Eye Exam: 2024 Dilation YES NO Optomap YES NO

Were you referred by your family eye doctor? YES NO Were they prescribed? Glasses Contact Lenses

If not your family eye doctor, whom can we thank for the referral? Dr. Tonya Bourn

Address or Contact info if known:

Reason for exam today:
BV FU

MEDICAL INFORMATION

Medical Doctor's Name: Dr. MARK FOGARTY Date of Last Exam: 2023

Does the Physician have any areas of concern regarding your health?
No

Have you received any of the following examinations? Check any that apply and type in the name of the provider.

Neuropsychological: Speech/Hearing Specialist:
 Occupational Therapist: X Other Specialist: Dry Eye Institute - Dr. Tonya Bourn
 Physical therapy: Chiropractic treatment

Results/Recommendations:

REVIEW OF SYSTEMS

Review of Systems: Please mark EACH BOX Yes or No for the following. If Yes, please describe in the space provided:

YES X NO General Constitutional (unexplained fever, weight loss or gain, etc.)
 YES NO Eyes (Disease related such as Glaucoma, Detached Retina) Dry Eye Disease
 YES NO Ears, Nose, Throat, Mouth (Hearing loss, chronic nasal congestion, chronic cough) nasal congestion - had inferior turbinate reduction surgery
 YES X NO Respiratory (Asthma, chronic bronchitis, shortness of breath, etc.)
 YES X NO Cardiovascular (Diabetes, hypertension, heart problems, etc.)
 YES X NO Gastrointestinal (Diarrhea, constipation, hernia, ulcers, etc.)
 YES NO Genitourinary (Painful urination, frequent urinations, jaundice, etc.) 0.9 mg/dL levels of bilirubin in the blood which the doc said was a bit high...
 YES X NO Hematological/Lymphatic (anemia, bleeding problems, etc.)
 YES X NO Musculoskeletal (Muscle pain, trauma, osteoarthritis, osteoporosis, etc.)
 YES X NO Skin (Eczema, Psoriasis, rashes, etc.)
 YES X NO Neurological (Epilepsy, Cerebral Palsy, tumor, autism, etc.)
 YES NO Psychiatric (ADHD, Depression, anxiety, etc.) Depression, anxiety, other undiagnosed
 YES X NO Endocrine (Diabetes, Thyroid problems, etc.)
 YES X NO Allergic/Immunological (Please list all food and environmental allergies)

Family History

<input type="checkbox"/> Unknown family history	Relationship:
Stroke	<input type="checkbox"/> Yes X <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes X <input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes X <input type="checkbox"/> No
Blindness	<input type="checkbox"/> Yes X <input type="checkbox"/> No
Macular Degeneration	<input type="checkbox"/> Yes X <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes X <input type="checkbox"/> No
Retinal Detachment	<input type="checkbox"/> Yes X <input type="checkbox"/> No

Strabismus/Amblyopia

Yes No

Other:

SOCIAL HISTORY

Smoking Status	Never smoker (<100 cigs equiv)	Type	How Long	Discussed Cessation	No
Alcohol	Socially	Type	How Long		
Illegal Drugs	No	Type	How Long	STD	
Race		Ethnicity		Preferred Language	

DEVELOPMENTAL HISTORY **This is only for patients under 18**

Mark EACH BOX Yes or No regarding your child's development history. If Yes, please explain in the box provided.

YES NO Delays in GROSS motor development (i.e. difficulties learning to ride a bike, catch a ball, play sports etc.)?

YES NO Delays in FINE motor development (i.e. difficulties learning to use scissors, tie shoes, draw/write etc.)?

YES NO Delays in learning to crawl or walk? (please note if child skipped crawling)

YES NO Other Developmental Delays

OTHER SYMPTOMS (For Children in addition to the previous symptoms)

YES NO Did your child repeat a grade or have a delayed start? Explain:

YES NO Has your child received special tutoring or remedial assistance? Explain:

YES NO Do you have any concerns about your child's behavior? Explain:

How long does it typically take your child to complete a 20 minute assignment?

Is your child performing up to their potential?

Is there any other information you feel would be helpful/important in your treatment?

Addendum:

Date of injury/trauma 2020

Was this a work related injury and if so, what is the name of your employer and your job description
No

Explain what occurred Head injury from fall, gash on left eyebrow

Did you lose consciousness? If so, please estimate how long No

Please list any visual symptoms you noticed right after the injury None

Please list any treatment that occurred right after the injury CT scan showed no brain swelling.

If any visual symptoms began post-injury, please list and estimate date of occurrence None

Please list any treatments you have tried. Include ongoing treatment and providers

Have you ever had any other brain injuries, diagnosed or suspected? Please list the date of injury ~2010 - needed scalp staples and lost consciousness

Addendum:

Unaided Visual Acuity Dist		Acuity with Glasses Dist		Acuity with Contacts Dist		Near
sc OD: 20/	sc OS: 20/	cc OD: 20/ 20	cc OS: 20/ 20	cc OU: 20/ 25-1	cc OS: 20/ 25	cc OD: 20/
sc OS: 20/	sc OS: 20/	cc OS: 20/ 20	cc OS: 20/ 20	cc OU: 20/ 20/2	cc OS: 20/ 20	cc OS: 20/
sc OU: 20/	sc OU: 20/	cc OU: 20/ 20	cc OU: 20/ 20	cc OU: 20/ 20/2	cc OU: 20/ 20	cc OU: 20/

Visual Field OD	OS	K's OD:	@	/	@
Pupils OD:	Dim	Light	K's OS:	@	/
Pupils OS:	Dim	Light			

Notes:

Cover Test

Distance CT without Rx Distance CT with Rx Ortho CT with Probe

Near CT without Rx Near CT with Rx 4 xp' x 9 9 Gaze

EOM: Full and Smooth

NPC: TTN x3

NSUCO Pursuits 5 5 5 5
NSUCO Saccades 5 5 5 5

Midine Shift

Notes:

Hab Rx OD: -2.50	-1.00	180	AR OD: -2.50	-1.25	007	Ret OD:
Hab Rx OS: -3.00	sph		AR OS: -3.00	-0.25	034	Ret OS:
Add: Sync III 9		Prism				
Sub OD	20/		FCC		Add:	Near OD: 20/
Sub OS	20/	Dist OU: 20/	+0.25			Near OS: 20/
						Near OU: 20/ 20

Notes: near testing through habitual

Near Ret OD	Cyclo AR OD	Cyclo Ret OD	Cyclo Ref OD
Near Ret OS	Cyclo AR OS	Cyclo Ret OS	Cyclo Ref OS

Dist Phoria H: 3 xp 2 BU V:	Dx	vg	Distance BI: Distance BO:		NRA: +2.00	/
Near Phoria H: 12 XP' V: ortho		vg Near	Near BI: x Near BO: x	24 24	20 20	PRA: -2.50 / Acc Facility CPM: Verg Facilities

Phoria Add:
V: Near

Notes

	H Prism	V Prism
Final Rx OD:		
Final Rx OS:		

Add: Use No charge dr remake

Recom

H Prism V Prism

Final Rx 2 OD:

Final Rx 2 OS:

Add: Use

Recom

H Prism V Prism

Final Rx 3 OD:

Final Rx 3 OS:

Add: Use

Recom

Addendum:

CHIEF COMPLAINT

Primary

Secondary

ASSESSMENT

- 1 H51.11 Convergence insufficiency
2 H50.53 Vertical heterophoria
3 H55.82 Deficient smooth pursuit eye movements
4 H55.81 Saccadic eye movements

5

6

7

8

9

10

11

12

PLAN

Sensorimotor eval. Doing well post VT. continue HVT prn. Pt owns box.

continue current specs. rtc prn.

25 min

Class/work recom

NOTES

Patient Education

Return Visit

Reason:

 FILLED OUT DL FORM, GAVE TO PATIENT, UPLOADED TO "FILES"**BILLING**

- 1 99213 99213 Established patient, detailed
2 92060 92060 Sensorimotor/BV Eval Level 1

3

4

5

6

 CODE BY TIME (see Code By Time Tab)

Addendum:

Ignore this record for Meaningful Use

Field Color Guide MU3 CQMs Multiple Reporting Agencies

Notes

Status - Allergy Agent - Reaction - Severity
- Empty List - -

X No known drug allergies

Is Primary Care Provider?

Prescribed Date - Medication Name - Status - Form
05/30/2024 - Ritalin - Active -

- Transitioned In Referred In
- Patient Transferred In/Referred To This Provider
- Medication Reconciliation performed
- Summary of care provided for transfer
- Received Consultant Rpt
- Asked for electronic copy
- Received electronic copy
- E-Prescribed medication
- Patient has received clinical summary of this visit
- Patient was provided education resource
- (By checking this box, you agree that Crystal was used to determine proper resource)

Medications Documented Reason Current Medications Not Documented

Reason Current Medications Not Documented (AOA)

Pharmacy

Race

Ethnicity

Preferred Language

Sexual Orientation

Race (More Granular)

Ethnicity (More Granular)

Gender Identity

Height

ft

Weight

in

Blood Pressure

/

Body Temperature

BMI

BMI Percentile

BMI Followup?

Counseling Physical Activity

Reason Diastolic Blood Pressure Not Taken

Hypertension?

Reason BMI Not Done

Counseling Nutrition

Reason Systolic Blood Pressure Not Taken

HbA1c Lab Test Result

Recv Flu Immun.

Heart Rate Respiratory Rate Pulse Oximetry

Smoking Status

Never smoker (<100 cigs equiv)

Discussed Cessation

No

Tobacco Use

Tobacco Non-User

Current non-smoker (finding)

Tobacco Use Screening

Tobacco smoking status NHIS

Reason Tobacco Use Screening Not Done

Tobacco Use Cessation Counseling

Reason Tobacco Use Cessation Counseling Not Done

Cup to Disc ratio OD

Cup to Disc ratio OS

Reason Cup to Disc Ratio Not Done

H

V

H

V

Optic Nerve Evaluation

Optic disc or retinal nerve abnormalities:

OD OS

Reason Optic Disc Exam for Struct. Abnorm. Not Done

Optic Disc Exam for Structural Abnormalities - Result - Right Eye

Optic Disc Exam for Structural Abnormalities - Result - Left Eye

Dilated Macular/Fundus Exam Macular Edema Reason Macular Exam Not Done

Macular Edema Findings Present Type

Macular Edema Findings Present Type Communicated

Reason Not Communicated - Macular Edem

Macular Edema Findings Absent Type

Macular Edema Findings Absent Type Communicated

Reason Not Communicated - Macular Edem

Communicated to Diabetes Care Provider:
Exam Findings Severity of Retinopathy

Retinopathy Severity Level

Level of Severity of Retinopathy Type Communicated

Retinal or Dilated Exam Negative Finding

Reason Not Communicated - Level of Severity of Retin

Retinal/Dilated Eye Exam Retinal or Dilated Eye Exam Type (AOA)

Retinal or Dilated Eye Exam Type

Fall Screening

Depression Screening Result

Reason Depression Screening not taken

 Depression Screening

Diagnosis Code	Description
H51.11	Convergence insufficiency
H50.53	Vertical heterophoria
H55.82	Deficient smooth pursuit eye movements
H55.81	Saccadic eye movements

Bill ID

CPT

Description

99213

99213

Established patient, detailed

92060

92060

Sensorimotor/BV Eval Level 1

Billing Modifiers Description

Date - Type - Primary - Status - Code - Problem - Code System - Nullflavor - Value Set - Start Date - End Date - Notes MU Measures Outside Of Crystal PM
 Medication Orders
 Lab Orders
 Radiology Orders
 Imaging Orders (non-Radiology)
 # Linked Images

Relationship - Disease or Condition
Empty List - Unknown family history

PQRS Billing Grid

Chief Complaint (SNOMED)

Bill ID - CPT - Bill Description - Modifier Code - Modifier Description

Code:

Description:

System:

Participants

Informant - Title - First - Middle - Last - Relation - Area Code - Phone - Address1 - Address2 - City - State - Zip - Country

Care Team

Employee - Data Enterer - Participation Function - Taxonomy - Title - First - Middle - Last

Procedures

Date - Code - Description - Code System - Nullflavor - TS Code - TS Description - TS Code System - Start Date - End Date - Reason Done - Reason Not Done - Discharge Disposition - Performer

Vital Signs

Code - Value - Unit - Start Date - End Date

Smoking Status

Date - Code - Code (AOA) - Obs. Start Date - Obs. End Date - Start Date - End Date

Implantable Devices

Show Inactive

Date - Status - Start Date - End Date - Description-GMDN - Brand Name - Version or Model Number - Company Name - Device Identifier - UDI - Lot-Batch - Serial Number - Contains NRL

Type - Plan

Interventions

Date - Code - Nullflavor - Category - Reason Done - Reason Not Done - Start Date - End Date - Performed Start Date - Performed End Date

Diagnostic Study Grid

Date - Code - Description - Code System - Value Set - Nullflavor - Reason Not Done - Order Date - Performed Start Date - Performed End Date

Addendum:

Spectacle Rx 1

OD	Sphere	Cylinder	Axis	Vert Prism	Hori Prism	Add	Seg Ht	Dist PD	Mono PD
OS								Near PD	

Notes:

Contact Lens Rx 1

OD	X Disposable	X Sphere	Manufacturer	Series	Base Curve	Diameter	Sphere	Tint
OS								

OS

Notes: