

| | | |
|--------------------------|-----------------------------|------------|
| 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 |
| Tab Filled Out | : Pretest [pages:1] | |
| | : Chief Complaint [pages:1] | |
| | : Medical History [pages:2] | |
| | : TBI History [pages:1] | |
| | : Exam [pages:2] | |
| | : A & P [pages:1] | |
| | : ARRA [pages:4] | |
| | : SRx [pages:1] | |

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

sc OD: 20/ sc OD: 20/

Add: Sync III 9

sc OS: 20/ sc OS: 20/

Style

sc OU: 20/ sc OU: 20/

Prism

Acuity with Glasses Dist Near

cc OD: 20/20 cc OD: 20/ 25-1

Hab Rx 2 OD:

Hab Rx 2 OS:

Add:

cc OS: 20/ 20 cc OS: 20/ 25

Style

cc OU: 20/20 cc OU: 20/ 20/2

Prism

Acuity with Contacts Dist Near

cc OD: 20/ cc OD: 20/

Hab Rx 3 OD:

Hab Rx 3 OS:

Add:

cc OS: 20/ cc OS: 20/

Style

cc OU: 20/ cc OU: 20/

Vo

AR OD: -2.50 -1.25 007

AR OS: -3.00 -0.25 034

Series

BC

Diam

Pre

Pupillary Distance

CL Rx OD:

CL Rx OS:

OD PD

Sph

Cyl

Axis

Add

OS PD

X

Binoc

X

King Devick

VF Screening:

Test I

Stereo:

OD

Test II

Fly

+

OS

Test III

Age Expected

Animals

3/3

Color Vision:

Total Time

Wirt Circles

5/10

IOP 1

Errors I

Randot Circles

4/8

Tonometry OD:

Tonometry OD:

Errors II

Randot Large Shapes

8/8

Tonometry OS:

Tonometry OS:

Errors III

Age Expected

Dinosaur

Method:

Method:

Total Time

Fixation Disparity slightly exo / 0

Time:

Time:

Trial Frame

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? X Yes ___ No

Have you ever been prescribed glasses or contacts? X 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:

___ Occupational Therapist:

___ Physical therapy

___ Speech/Hearing Specialist:

X Other Specialist: Dry Eye Institute - Dr. Tonya Bourn

___ 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.)

X YES ___ NO

Eyes (Disease related such as Glaucoma, Detached Retina)

Dry Eye Disease

X 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.)

X 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.)

X 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

___ Unknown family history

Relationship:

Stroke

___ Yes X No

Diabetes

___ Yes X No

High blood pressure

___ Yes X No

Blindness

___ Yes X No

Macular Degeneration

___ Yes X No

Glaucoma

___ Yes X No

Retinal Detachment

___ Yes X No

Strabismus/Amblyopia

___ Yes X 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___ NODelays in GROSS motor development (i.e. difficulties learning to ride a bike, catch a ball, play sports etc.)?

___ YES___ NODelays 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___ NOOther 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 recieved 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 OD: 20/ | cc OD: 20/ 20 | cc OD: 20/ 25-1 | cc OD: 20/ | cc OD: 20/ | | |
| sc OS: 20/ | sc OS: 20/ | cc OS: 20/ 20 | cc OS: 20/ 25 | cc OS: 20/ | cc OS: 20/ | | |
| sc OU: 20/ | sc OU: 20/ | cc OU: 20/ 20 | cc OU: 20/ 20/2 | cc OU: 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 | | | |

| | | | | | | | |
|---------------|--|--|--|--|--|--|--|
| Midline 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 | vg | Distance BI: | NRA: +2.00 | / |
| 2 BU Dx | | Distance BO: | PRA: -2.50 | / |
| V: | | | | |
| Near Phoria H: 12 XP' | vg | Near BI: x | 24 | 20 |
| ortho | Near | Near BO: x | 24 | 20 |
| V: | | | | |
| 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

H Prism

V Prism

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

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

Is Primary Care Provider?

___ 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)

___ No current medications

| Medications Documented | Reason Current Medications Not Documented |
|--|--|
| <p>1. <i>Aspirin</i></p> <p>2. <i>Metoprolol</i></p> <p>3. <i>Lisinopril</i></p> <p>4. <i>Atorvastatin</i></p> <p>5. <i>Levothyroxine</i></p> <p>6. <i>Hydrochlorothiazide</i></p> <p>7. <i>Warfarin</i></p> <p>8. <i>Insulin</i></p> <p>9. <i>Acetaminophen</i></p> <p>10. <i>gabapentin</i></p> <p>11. <i>gabapentin</i></p> <p>12. <i>gabapentin</i></p> <p>13. <i>gabapentin</i></p> <p>14. <i>gabapentin</i></p> <p>15. <i>gabapentin</i></p> <p>16. <i>gabapentin</i></p> <p>17. <i>gabapentin</i></p> <p>18. <i>gabapentin</i></p> <p>19. <i>gabapentin</i></p> <p>20. <i>gabapentin</i></p> <p>21. <i>gabapentin</i></p> <p>22. <i>gabapentin</i></p> <p>23. <i>gabapentin</i></p> <p>24. <i>gabapentin</i></p> <p>25. <i>gabapentin</i></p> <p>26. <i>gabapentin</i></p> <p>27. <i>gabapentin</i></p> <p>28. <i>gabapentin</i></p> <p>29. <i>gabapentin</i></p> <p>30. <i>gabapentin</i></p> <p>31. <i>gabapentin</i></p> <p>32. <i>gabapentin</i></p> <p>33. <i>gabapentin</i></p> <p>34. <i>gabapentin</i></p> <p>35. 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Reason Current Medications Not Documented (AOA)

Pharmacy

| Race | Ethnicity | Preferred Language |
|------|-----------|--------------------|
|------|-----------|--------------------|

Sexual Orientation

Race (More Granular) Ethnicity (More Granular) Gender Identity

| Height | Weight | Blood Pressure | Body Temperature | BMI | BMI Percentile | BMI Followup? | Counseling Physical Activity |
|--------|--------|----------------|------------------|-----|----------------|---------------|------------------------------|
| ft | in | lbs | / | | | | |
| | | | | | | | |

| Reason Diastolic Blood Pressure Not Taken | Hypertension? | Reason BMI Not Done | Counseling Nutrition |
|---|---------------|---------------------|----------------------|
| | | | |

Reason Systolic Blood Pressure Not Taken HbA1c Lab Test Result Recvd Flu Immun.

Heart Rate Respiratory Rate Pulse Oximetry

| | |
|--------------------------------|---------------------|
| Smoking Status | Discussed Cessation |
| Never smoker (<100 cigs equiv) | No |

| Tobacco Use | Tobacco Non-User |
|--------------------------|------------------------------|
| Current smoker (finding) | Current non-smoker (finding) |

| Tobacco Use Screening | Reason Tobacco Use Screening Not Done |
|-----------------------------|---------------------------------------|
| Tobacco smoking status NHIS | |

[illegible]

| 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 Edema

Macular Edema Findings Absent Type

Macular Edema Findings Absent Type Communicated

Reason Not Communicated - Macular Edema

Communicated to Diabetes Care Provider:Retinopathy Severity Level

Exam FindingsSeverity of Retinopathy

Level of Severity of Retinopathy Type Communicated

Retinal or Dilated Exam Negative Finding

Reason Not Communicated - Level of Severity of Retinopathy

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

Retinal or Dilated Eye Exam Type

Fall Screening

Depression Screening

Depression Screening Result

Reason Depression Screening not taken

| Diagnosis Code | Description | Bill ID | CPT | Description |
|----------------|--|---------|-------|-------------------------------|
| H51.11 | Convergence insufficiency | 99213 | 99213 | Established patient, detailed |
| H50.53 | Vertical heterophoria | 92060 | 92060 | Sensorimotor/BV Eval Level 1 |
| H55.82 | Deficient smooth pursuit eye movements | | | |
| H55.81 | Saccadic eye movements | | | |

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)

Code:Description:System:

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

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 - Perform

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:

Electronically signed by: Dr. Schwalb, OD, Lauren 07/29/2024

SpectacleRx 2

| | | | | | | | | | |
|----|--------|----------|------|------------|------------|-----|--------|---------|---------|
| | Sphere | Cylinder | Axis | Vert Prism | Hori Prism | Add | Seg Ht | Dist PD | Mono PD |
| OD | | | | | | | | | |

OD

OS

Notes:

Contact Lens Rx 3

X Disposable

X Sphere

Manufacturer

Series

Base Curve

Diameter

Sphere

Tint

OD

OS

Notes: