REASON FOR VISIT: , Mr. ABC is a 61-year-old Caucasian male who presents to us today as a new patient. He states that he has difficulty with both his distance vision and also with fine print at near.,HISTORY OF PRESENT ILLNESS:, Mr. ABC states that over the last year, he has had increasing difficulty with distance vision particularly when he is driving. He is also having trouble when he is reading. He does occasionally wear over-the-counter reading glasses, which do help with his near vision.,Past ocular history is significant for astigmatism for which he wore glasses since he was 18 years old. However, Mr. ABC mentioned today that he has not worn his glasses for the last few years.,His past medical history is significant for hypertension, low serum testosterone level, hypercholesterolemia, GERD, depression, actinic keratoses, and a history of Pityrosporum folliculitis.,His family history is significant for diabetes in both parents. He states that his mother is seen by Mrs. Goldberg, but he is not aware of her ocular history. He has no known family history of glaucoma, age-related macular degeneration or hereditary blindness.,MEDICATIONS: , Wellbutrin XL 450 mg daily, Ritalin long-acting 60 mg daily, hydrochlorothiazide at an unknown dose, Vytorin at an unknown dose, and aspirin.,ALLERGIES: , No known drug allergies.,FINDINGS:, Visual acuity today without correction was 20/20 -2 pinholing to 20/16 in the right eye, and 20/40 +2 pinholing to 20/16 in the left eye. Near vision unaided was J2 in both eyes.,Manifest refraction today following pharmacological dilation was -0.50, +0.50 times 155 in the right eye revealing a

vision of 20/16. Manifest refraction was -1.00, +0.25 times 005 revealing a vision of 20/16 in the left eye. The add was +2 in both eyes. Visual fields are full to finger counting in both eyes.,Extraocular movements were within normal limits. Intraocular pressure by applanation was 16 mmHg in the right eye and 18 mmHg in the left eye measured at 11.30 in the morning.,Examination of the anterior segment was unremarkable in both eyes except for mild nuclear sclerotic opacities in both eyes.,Dilated fundus examination of the right eye revealed a sharp and pink optic disc with a healthy rim and cup-to-disc ratio of 0.7; however, there was central excavation of the disc, but no disc hemorrhages were noted. On examination of the macula, there were drusen scattered temporally. Examination of the vasculature was normal. Peripheral retinal examination was entirely normal.,On funduscopic examination of the left eye, there was a sharp and pink disc with a healthy rim, but with central excavation and a cup-to-disc ratio of 0.6. Of note, there were no disc hemorrhages. On examination of the macula, there was scattered tiny drusen centrally and superiorly. Examination of the vasculature was entirely normal. Peripheral fundus examination was unremarkable.,ASSESSMENT:,1. Age-related macular degeneration category three (right greater than sign left).,2. Glaucoma suspect based on disc appearance (increased cup-to-disc ratio and disc asymmetry).,3. Presbyopia and astigmatism.,4. Non-visually significant cataracts bilaterally.,PLANS:,1. The above diagnoses and management plans each were discussed with

the patient who expressed understanding.,2. Commence Ocuvite PreserVision capulets one tablet twice a day by mouth for age-related macular degeneration.,3. Humphrey visual field and disc photographs today for baseline documentation in view of glaucoma suspicion.,4. Followup in Glaucoma Clinic arranged in 4 months' time with repeat Humphrey visual fields at this time for reevaluation and comparison.,5. Follow up with Mrs. Braithwaite in the Comprehensive Eye Service Clinic for undilated refraction.,6. We will follow up this gentleman in our clinic in 12 months' time; however, I have asked him to return to us soon should he develop any worsening ocular symptoms in the interim.