Gilead Medical & Dental Centre

Examination Findings

Location: _____

Patient's Number: _____ Date DD / MM / YYYY _____

Name _____

Age _____ Gender ☐ M ☐ F Weight _____ kg

Dental Examination

Examination Findings (Please tick where appropriate)	*Remarks*
☐ Dental Plaques; require cleaning	_____
☐ Abscess/holes seen; requires urgent attention	_____
☐ Bleeding gums/gum problem; requires cleaning.	_____
☐ Problem with arrangement of teeth; requires specialist orthodontic treatment.	_____
☐ Normal teeth; requires regular Dental visits.	_____
☐ Misising tooth; requires tooth replacement	_____
☐ Retained baby teeth; requires urgent attention	_____
☐ Other problem; requires further consultation	_____

Dental Surgeon's Comments

Dental Surgeon's Signature _____

Eye Examination

	Remarks
☐ Difficulty reading small prints	_____
☐ Difficulty seeing objects from afar	_____
☐ Family history of blindness	_____
☐ Itching	_____
☐ Tearing	_____
☐ Pain	_____
☐ Burning Sensation	_____
☐ Other	_____

Unaided VR _____ VL _____ **Aided** VR _____ VL _____

Near VR _____ VL _____

C/C _____

Ocular Examination

	OD	OS
Eyelid		
Conj		
Cornea		
AC		
Med		
Fundus		
IOP		

OE Assessment

Refraction

Auto Ref: OD _____ OS _____

PD _____

Subj Ref: OD _____ OS _____

ADD _____ VR _____ VL _____

Optometrist's Comments

Optometrist's Signature _____