EYE OPTIQUE

Name _____ Date ___/___/___
Last First Middle

Address _____ AGE _____

City _____ State _____ Zip _____ Birth Date ___/___/___

Phone (Home) _____ (Work) _____

Occupation/Hobbies _____ Email Address: _____

Do *You* Have?	(Circle)	
Diabetes	Yes	No
High Blood Pressure	Yes	No
Heart Trouble	Yes	No
History of Stroke	Yes	No
Arthritis	Yes	No
Asthma/Breathing Disorder	Yes	No
Thyroid Problem	Yes	No
Cancer	Yes	No
Kidney Problem	Yes	No
Liver-Hepatitis	Yes	No
Are you pregnant?	Yes	No
Infectious disease	Yes	No
Do you smoke	Yes	No

Other MEDICAL PROBLEMS _____

Allergies to medication Yes No * If yes, please list: _____

_____

Please List all Medications:

_____

_____

_____

_____

Surgery/Injury Dates: _____

_____

_____

	(circle)	
Were you told you have a Cataract?	Yes	No
Do you have Glaucoma?	Yes	No
Do you have a family history of Glaucoma?	Yes	No
Do you have family history of Blindness?	Yes	No
Do you have Macular Degeneration?	Yes	No
Have you ever injured your eyes?	Yes	No
Have you ever had surgery on your eyes?	Yes	No
Are you seeing floating objects?	Yes	No
Are you seeing flashing lights?	Yes	No
As a child, were you told you had a lazy eye?	Yes	No
Were you told you had an eye turn in/out?	Yes	No
Do you wear contact lenses?	Yes	No
Have you had a contact lens eye infection?	Yes	No
Do you have any other eye problem?	Yes	No

children under 18

Normal reading level
Yes No
_____
_____

Normal development
Yes No
_____
_____

Childhood diseases
Yes No
_____
_____

Signature: _____ (Please circle) Self/Spouse/Parent or Guardian

Reason for your visit, Check and circle ones that apply:

- ☐ Need new glasses (broke, lost, dislike, too weak)
- ☐ Want contact lenses/need more contacts.
- ☐ Routine eye exam-no ocular or visual problems

Name_____ AGE:___ ALLERGIES: NKA/_____ Date:___/___/___

History: Ocular [ ] Reviewed [ ] No Change as of __/__/__ [ ] Updated _____
Medical [ ] Reviewed [ ] No Change as of __/__/__ [ ] Updated _____
Family [ ] Reviewed [ ] No Change as of __/__/__ [ ] Updated _____
Social [ ] Reviewed [ ] No Change as of __/__/__ [ ] Updated _____

CC:_____ ocular Meds: _____

20/ 20/ 20/ J- @
sc cc PH
20/ 20/ 20/ J- @

Old RX OD _____ - _____ X _____ ADD +_____
OS _____ - _____ X _____ ADD +_____
Old CL OD _____ BC___D___T_____
RX OS _____ BC___D___T_____

RET OD _____ - _____ X _____
OS _____ - _____ X _____

K'S OD _____/_____
OS _____/_____

Final RX OD _____ - _____ X ____ 20/ ADD +____
OS _____ - _____ X ____ 20/ +____

Final CL RX OD _____ BC___D___T___
OS _____ BC___D___T___

SR IO IO SR

PERRL (-)APD (+)APD CVF: FTFC/ restricted OD EOMS: full/ restricted OD
FTFC/ restricted OS full/ restricted OS SR IO IO SR

TA OD ___ OS ___ mmHG @ __:__ Goldman CT:_____ CV:__/__OD __/__OS sterio____

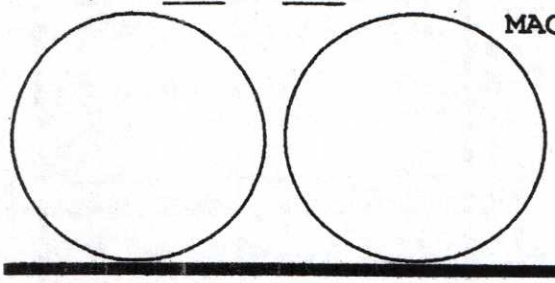
SLE: OD OS
Lid/Lash _____/_____
Comea: _____/_____
Conj _____/_____
A/C _____/_____
Iris _____/_____
Lens: Phakic, aphakia, pseudophakia____OD
Phakic, aphakia, pseudophakia____OS

CONTACT LENS EVAL.
good/poor coverage
good/poor comfort
good/poor movement
OD OS
_____
_____

GONIO: X X __PAS__NVA__PIG__REC
sussman 4 mirror

DFE: 1gtt OD/OS/OU @__:___ Tropicamide 1%,0.5% Phenylephrine 2.5% cyclo 0.5%,1% 78D 90D 20D

C/D: ___ OD___ OS



MAC: _____OD _____OS

OD NFL OS PR: ___holes ___tears ___elevations OD
___holes ___tears ___elevations OS

(+) (-) PVD OD PP_____OD

(+) (-) PVD OS PP_____OS

IMPRESSION:

PLAN:

Complete exam: return in___year___months ___week(s)

☐ Findings and recommendations discussed. All questions answered.

☐ Told of risk of permanent decrease in best corrected vision secondary to infection from contact lens wear even with proper care. Told to RTC immediately if any symptoms of infection occur.

POLYCARBS DISCUSSED/ADVISED, UV, HIGH INDEX, PROGRESSIVES, FT___, round seg SIGNATURE _____OD