AN ANALYSIS OF COGNITIVE AND AFFECTIVE COMPONENTS OF NORTH AMERICAN OPTOMETRY SCHOOL CLINICS' PRIMARY CARE EXAMINATION DOCUMENTS

by

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Has been approved

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_____

Doctoral Candidate

___April 1st, 2010 _____

Date

ABSTRACT

Background: The cognitive and affective learning domains can greatly impact patient care; however, it is reported that most doctors emphasize the cognitive domain. And since patient care examination documents generally guide the examinations, this study intends to investigate the primary care examination documents of the North American Optometry School Clinics to determine their relative cognitive and affective content. *Methods:* The clinic directors at all North American Optometry Schools (including Puerto Rico and the two schools in Canada) will be contacted and requested to send copies of their primary eye care examination case history and examination forms. Once received, a system will be determined to evaluate the content of the forms to determine measures of cognitive and affective emphasis. *Results:* At the time of data collection, 19 schools were contacted for the purpose of collecting the data. 14 responded and provided their case history and primary eye care examination forms. A 74% response rate was pleasantly surprising but nonetheless it was hoped all the schools would have responded. The analysis of the cognitive and affective components in the primary care examination forms will be reported for the documents received from the North American Optometry Schools. *Conclusions:* The results of this study will be summarized and analyzed for potential significance.

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Introduction:

The importance of data collected in an optometric examination is based upon the number of elements assigned to different domains. During collection of examination data, such as acuities, pupils, extra ocular muscle testing and so forth, the clinician tends to follow protocols and record keeping practices in place at their institution. The emphasis of various domains typically begins with students in optometric institutions, which then translates into practice upon graduation. The word domain is used here to specify various components in an optometric examination, whether it be cognitive or affective components. The variables typically noted in an examination form tend to dictate the flow of the exam, and creates a certain structure for an exam. This was illustrated by Varpio et al, who pointed out the impact of the record placing on the interaction, and the role the patient record has (Fylan & Grunfeld, 2002). In record keeping forms, cognitive domains are generally much more emphasized than affective domain, based on prior experience with such records. Many clinicians rely on their observational skills in noting affective components, without physically recording them. The literature has as of yet to conduct a thorough evaluation of the different cognitive and affective domains in optometry examinations. One article explored the importance for patient understanding and comprehension of the collection process of optometric information (Lecoq, 2002), but did not detail the variables and provide a comparison. Similarly, another articles looking at improving record keeping descriptions in monitoring systemic hypertension (Wolffsohn et al, 2001). It is apparent from the scarcity of research that there is a need for more in the discussed subject matter.

Rationale:

While the collection of cognitive information remains of great importance during an eye care exam, the affective components that often go undocumented are also quite significant. A comparison and contrast of the domains present in North American optometry schools has never been conducted, as per a thorough literature search. Such research will aid in identifying the strengths and weaknesses of the schools' record keeping practices.

Methods:

The clinical directors of all North American optometry schools, including Canada, were contacted, in an attempt to collect copies of their primary eye care examination forms. The response rate was 74% (14 out of 19 schools responded). The forms were reviewed, outlining several cognitive and affective domains, and will be further analyzed to determine which schools contain, and which lack the chosen variables. 5 cognitive and 5 affective domains will be chosen for further determination of their presence in the collected examination forms. 5 were chosen for preliminary comparisons and contrast, as this report serves as a proposal for future experimentation and research in the subject matter at hand. Randomly, the 5 cognitive domains chosen were visual acuity, cover test, pupils, refraction, and posterior pole evaluation. The 5 affective domains chosen were mood, affect, orientation, receptiveness to doctor, and whether or not a patient asked questions.

Results:

Upon evaluation of the examination forms, 5 domains were selected from the cognitive and affective categories. Visual acuity, cover test, pupils, refraction, and posterior segment evaluation were selected as cognitive domains. The following is a table outlining whether or not these were present in the schools' examination forms:

Table 1: Cognitive Domains

School	**Domain**				
	Visual Acuity	**Cover Test**	**Pupils**	**Refraction**	**Posterior Segment Evaluation**
Nova	Present	Present	Present	Present	Present
University of Montreal	Present	Present	Present	Present	Present
Southern	Present	Present	Present	Present	Present
University of Waterloo	Present	Present	Present	Present	Present
Berkley	Present	Present	Present	Present	Present
Indiana	Present	Present	Present	Present	Present
MCO	Present	Present	Present	Present	Present
Northeastern	Present	Present	Present	Present	Present
OSU	Present	Present	Present	Present	Present
Pacific	Present	Present	Present	Present	Present
SCO	Present	Present	Present	Present	Present
SUNY	Present	Present	Present	Present	Present
UAB	Present	Present	Present	Present	Present

As the table illustrates, all cognitive domains chosen are present. The records do not fall short in having the key components present to be properly documented. Table 2 illustrates the affective domains present in the examination forms:

Table 2: Affective Domains

School	Domain				
	Mood	**Affect**	**Orientation**	**Receptive to Doctor**	**Asks Questions**
Nova	Present	Present	Present	Absent	Absent
University of Montreal	Absent	Absent	Absent	Absent	Absent
Southern	Present	Present	Present	Absent	Absent
University of Waterloo	Absent	Absent	Absent	Absent	Absent
Berkley	Present	Present	Present	Absent	Absent
ICO	Absent	Present	Present	Absent	Absent
Indiana	Absent	Present	Present	Absent	Absent
MCO	Present	Present	Present	Absent	Absent
Northeastern	Present	Present	Absent	Present	Present
OSU	Absent	Absent	Absent	Absent	Absent
Pacific	Present	Present	Present	Absent	Absent
SCO	Present	Present	Present	Absent	Absent
SUNY	Absent	Absent	Absent	Absent	Absent
UAB	Present	Present	Present	Absent	Absent

Two further affective domains were created that were absent in most forms: receptiveness to doctor, and whether or not the patient asked questions. Out of 14 schools, Northeastern was the only school to have a checkbox that addressed these two domains. Most schools included mood, affect, and orientation, which are compliant with Medicare guidelines. Several U.S schools, however, failed to include some or all of these components. Both Canadian schools failed to include any affective domains, which may be attributed to different documentation guidelines. Overall, the three standard affective domains were present for most optometry schools, and the two additional were absent in almost all forms.

Discussion:

Initial examination of the data would indicate that further analysis is necessary to properly discern whether the affective components in place in most record keeping forms for the schools are indeed effective or not. Emphasis on cognitive domains is undoubtedly present in eye care examination forms. A preliminary look at the data collected illustrates a lack of attentiveness towards affective domains; hence further concentration on such components is warranted. When it comes to patient education, diagnosis, impression and treatment plans, assessing the effectiveness of the message conveyed to the patient can be interpreted by the initial observation and recording of patient mood, affect, orientation, etc. Also, a primary eye care provider, identifying affective issues in a patient's life, in order to properly educate and direct them to further care is essential, as mental health contributes to physical health in general.

Conclusion:

Initial examination of the cognitive and affective elements present in North American Optometry schools' examination forms demonstrates the need for further research into this subject matter. Upon conducting a literature search, it was determined that this area is fairly under researched, if looked upon at all. By strengthening affective domains, the optometric examination in general will be strengthened and evaluation of treatment plans and patients' receptiveness can be further evaluated.

REFERNCES

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APPENDIX A

NOVA FORMS

THE EYE INSTITUTE AT NOVA SOUTHEASTERN UNIVERSITY

Patient Name:	
Date of Birth:	Date:

The following is a review of your overall health. The questions are divided into different body systems. Please answer yes (Y) if you have or have ever had the following conditions or no (N) if you have not. There is a blank space for you, marked 'Other', to add conditions we do not specifically inquire about. Please provide any additional information about your health on the back.

Last Eye Examination:_____ **Last Physical Examination:**_____

Ocular / Eye

Y	N	Glaucoma
Y	N	Cataracts
Y	N	Macular degeneration
Y	N	Previous eye injury
Y	N	Previous eye surgery
Y	N	Burning
Y	N	Itching
Y	N	Tearing
Y	N	Seeing floating spots
Y	N	Seeing flashing lights
Y	N	Double vision
Y	N	Eye turn/Eye exercises
Y	N	Other:

Constitutional Symptoms (General Health)

Y	N	Fever
Y	N	Weight loss
Y	N	Other:

Endocrine (Hormones)

Y	N	Thyroid problems
Y	N	Diabetes
Y	N	Other:

Ears, Nose, Mouth, Throat

Y	N	Deafness
Y	N	Sinusitis
Y	N	Other:

Musculoskeletal

Y	N	Osteoarthritis
Y	N	Rheumatoid arthritis
Y	N	Osteoporosis
Y	N	Other:

Skin

Y	N	Itching
Y	N	New moles/growths
Y	N	Other:

Neurological

Y	N	Previous stroke
Y	N	Seizures
Y	N	Headache
Y	N	Other:

Cardiovascular

Y	N	High blood pressure
Y	N	Chest pain
Y	N	Heart valve disease
Y	N	Previous heart attack
Y	N	Hardening of arteries
Y	N	High cholesterol
Y	N	Other:

Blood / Lymphatic

Y	N	Anemia
Y	N	Cancer
Y	N	Other:

Gastrointestinal

Y	N	Loss of appetite
Y	N	Cancer
Y	N	Other:

Respiratory

Y	N	Asthma
Y	N	Chronic Bronchitis
Y	N	Wheezing
Y	N	Shortness of breath
Y	N	Other:

Genitourinary

Y	N	Kidney stones
Y	N	Prostate cancer
Y	N	Breast cancer
Y	N	Other:

Allergic / Immunologic

Y	N	Allergies
Y	N	Allergies to Medicines
Y	N	Autoimmune disease
Y	N	HIV/AIDS
Y	N	Other:

Psychiatric

Y	N	Depression
Y	N	Panic attacks
Y	N	Anxiety
Y	N	Other:

Please list your current medications:_____

_____

Please list previous surgeries:_____

Primary Care Doctor:_____ **Phone #:**_____

Additional Notes:	Additional Doctor's Notes:
Student Doctor: Date:	Attending: O.D. Date:

Revised November 2004

Patient Name:	Date:

Please provide any additional information about your health:_____

_____

_____

_____

_____

_____

Please sign and date each entry.

Additional Notes:	Additional Doctor's Notes:

Revised November 2004

THE EYE INSTITUTE AT NSU – PRIMARY CARE SERVICE

☐ Comprehensive Examination Only ☐ Comprehensive Examination + Annual CL Examination

Patient:_____ DOB:_____ Date:_____ Time Started: (am/pm)

Age/Gender/Race:_____ Student:_____ Attending OD:_____

Chief Complaint:	**Chief Complaint:**
Secondary c/o:	Secondary c/o:
HISTORY OF THE PRESENT ILLNESS (HPI):	**HPI:**
Location / Timing	Location / Timing
Quality / Context	Quality / Context
Severity / Modifying Factors	Severity / Modifying Factors
Duration / Associated S/S	Duration / Associated S/S
PAST, FAMILY AND SOCIAL HISTORY:	
POHx	POHx
FHx	FHx
Social: EtOH: Tob: Other:	Social: EtOH: Tob: Other:
Occupation/Hobbies:	Occupation/Hobbies:
REVIEW OF SYSTEMS FORM REVIEWED: ☐ yes ☐ no	**ROS FORM REVIEWED:** ☐ yes ☐ no
Changes:	Changes:
Psych: Oriented to: ☐ time ☐ place ☐ person	**Psych:** Oriented to: ☐ time ☐ place ☐ person
Mood/Affect: ☐ appropriate ☐ other:	Mood/Affect: ☐ appropriate ☐ other:

Habitual Rx OD / OS ☐ CLRx ☐ SRx

DVA OD_____OU_____ (sc/cc) OS_____

NVA OD_____OU_____ (sc/cc) OS_____

Contact Lens Rx _____
Replace: ☐1D ☐1W ☐2W ☐1M ☐Other____
Wearing Schedule: ☐DW ☐EW ☐FW
Care System: _____

VA		VA			VA		
distance sc	OD	distance ☐ CLRx ☐ SRx	OD ORx		near Thru	OD ORx	
	OS		OS ORx			OS ORx	
	OU		OU			OU	

PH: OD_____ OS_____ Thru_____

BP: _____ Pulse:_____BPM

EOM:_____ CF: _____OD

Pupils: _____ _____OS

Cover Test : D (sc/cc)_____ N (sc/cc)_____

CF:OS_____OD _____

EOM:_____

1° Gaze Alignment _____

Pupils: _____

Stereo (sc/cc) Global_____ Local _____ Method (_____) NPC_____

Color Vision OD _____ OS _____ Method (_____) PD_____ VD_____

BINOCULAR EXAMINATION

Method Used ☐ RP ☐ PB

Distance (Rx Used: _____)

Phoria: Lateral _____Vertical _____hyper

Negative Vergences _____/_____/_____

Positive Vergences _____/_____/_____

Vertical Vergences OD BU_____BD_____

Near (Rx Used: _____)

Phoria: Lateral _____Vertical _____hyper

Negative Vergences _____/_____/_____

Positive Vergences _____/_____/_____

Vertical Vergences OD BU_____BD_____

Acc Amps.OD_____OS_____ Method_____

Keratometry	OD		clear/distorted
	OS		clear/distorted
Retinoscopy	OD		20/
	OS		20/
Refraction 1 wet dry	OD		20/
	OS		20/
Refraction 2 wet dry	OD		20/
	OS		20/
CL Related Measurements & Obs.	HVID	L/K	Dom Eye
	PFD	Lid Ten	Method

NRA:_____PRA:_____ thru_____

BCC:_____

Near Add: _____VA_____

_____VA_____

Trial frame: ,accepted Y / N

_____VA_____

_____VA_____

ADD:_____VA_____

Ranges:

Revised July 2006

THE EYE INSTITUTE AT NSU – PRIMARY CARE SERVICE

atient Name: _____ Date:

ADDITIONAL TESTS / CL TRIALS:

General Observation: ☐ Unremarkable ☐ _____

SLIT LAMP EXAM: OD / OS / OU ☐ NaFL

External Ocular Area TBUT TM

Lids/Lashes

Cornea

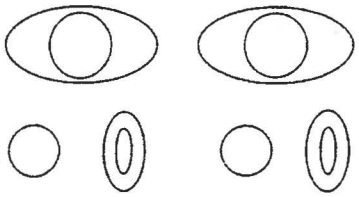
Conjunctiva < B P

Iris

Ant. Chamber

Lens

Vitreous



ngles: OD: N T OS: N T

T_{app}: _____mmHg OD _____mmHgOS @_____(am/pm)

Proparacaine 0.5% ☐ NaFL or _____

ilation: ☐ standard (1% Tropicamide/2.5% Phenylephrine)

☐ other:_____ ☐ Explained SE of DPA's

ILATED FUNDUS EXAM: OD / OS / OU ☐ 78D ☐ 90D ☐ 20D

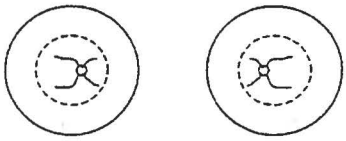
C/D

ONH

Macula

Vessels

Periphery



ASSESSMENT:

PLAN:

RX: **CLRX:**

☐ Current ☐ Dispensed ☐ Ordered

Replacement: ☐ 1D ☐ 1W ☐ 2W ☐ 1M ☐ Other_____

WS: ☐ DW ☐ EW ☐ FW _____ **CS:**_____

Modality: ☐ DVO ☐ Mono ☐ Multi ☐ Cosmetic ☐ Prosth ☐ Therap

TC:_____ For_____

I have reviewed the history and personally repeated key elements of the examination. Framed areas are for provider use only.

_____ QRS#

udent Optometric Physician

_____ O.D.

Attending Optometric Physician License#/Faculty Certificate#_____

vised July 2006

Université de Montréal
École d'optométrie
Cliniques

PRIMARY CARE CLINIC

DATE : / /
(day / month / year)

Personal information

Affix label here (if available)

FILE # : _____

LASTNAME	FIRST NAME
ADDRESS	DATE OF BIRTH (day / month / year) / / AGE
CITY	OCCUPATION
POSTAL CODE	TELEPHONE # WORK : ( ) HOME : ( )

Reason for consulting

You are consulting because...

- It is time for your routine examination ..... Yes ☐ No ☐ I do not know ☐
- Blurred distance vision ..... Yes ☐ No ☐ I do not know ☐
- Blurred near vision (reading) ..... Yes ☐ No ☐ I do not know ☐
- You experience double vision ..... Yes ☐ No ☐ I do not know ☐
- You experience eyestrain ..... Yes ☐ No ☐ I do not know ☐
- One eye turns in or out ..... Yes ☐ No ☐ I do not know ☐
- You have one of the following symptoms:
  - Itchiness ..... Yes ☐ No ☐ I do not know ☐
  - Dryness ..... Yes ☐ No ☐ I do not know ☐
  - Pressure ..... Yes ☐ No ☐ I do not know ☐
  - Redness ..... Yes ☐ No ☐ I do not know ☐
  - Burning sensation ..... Yes ☐ No ☐ I do not know ☐
  - Glare ..... Yes ☐ No ☐ I do not know ☐
  - Tearing ..... Yes ☐ No ☐ I do not know ☐
- You have headaches / migraines on a regular basis ..... Yes ☐ No ☐ I do not know ☐
- Your eyes fatigue easily ..... Yes ☐ No ☐ I do not know ☐
- You have noticed one of the following phenomena :
  - Flashing light ..... Yes ☐ No ☐ I do not know ☐
  - Distorted vision ..... Yes ☐ No ☐ I do not know ☐
  - Night vision problems ..... Yes ☐ No ☐ I do not know ☐
  - Loss of visual field ..... Yes ☐ No ☐ I do not know ☐
  - Change in color vision ..... Yes ☐ No ☐ I do not know ☐
  - Other : _____

Do you wear glasses ? ..... Yes ☐ No ☐ I do not know ☐

- If yes... do you wish to change them? ..... Yes ☐ No ☐ I do not know ☐
- If no... have you ever worn any ? ..... Yes ☐ No ☐ I do not know ☐

Do you wear contact lenses ? ..... Yes ☐ No ☐ I do not know ☐

- If no... do you want any ? ..... Yes ☐ No ☐ I do not know ☐
- If no... have you ever worn any ? ..... Yes ☐ No ☐ I do not know ☐

Reverse...

About your eyes

Do you or a family member suffer from (or has suffered from)

	Yourself	*Family member*
• Cataracts	Yes ☐ No ☐ I do not know ☐	Yes ☐ No ☐ I do not know ☐
• Glaucoma (high eye pressure)	Yes ☐ No ☐ I do not know ☐	Yes ☐ No ☐ I do not know ☐
• Lazy eye (amblyopia, strabismus)	Yes ☐ No ☐ I do not know ☐	Yes ☐ No ☐ I do not know ☐
• Retinal problems	Yes ☐ No ☐ I do not know ☐	Yes ☐ No ☐ I do not know ☐
• Corneal problems	Yes ☐ No ☐ I do not know ☐	Yes ☐ No ☐ I do not know ☐
• Partial or complete blindness	Yes ☐ No ☐ I do not know ☐	Yes ☐ No ☐ I do not know ☐
• Other	_____	_____

- Do you use eye drops ?..... Yes ☐ No ☐ I do not know ☐
- Were you ever prescribed any ?..... Yes ☐ No ☐ I do not know ☐
- Have you ever done visual training?..... Yes ☐ No ☐ I do not know ☐
- Have you ever had an eye injury, disease or operation ?..... Yes ☐ No ☐ I do not know ☐

About your health

Do you or a family member suffer from (or has suffered from)

	Yourself	*Family member*
• Hypertension (high blood pressure)	Yes ☐ No ☐ I do not know ☐	Yes ☐ No ☐ I do not know ☐
• Diabetes	Yes ☐ No ☐ I do not know ☐	Yes ☐ No ☐ I do not know ☐
• Cardiac problems (heart problems)	Yes ☐ No ☐ I do not know ☐	Yes ☐ No ☐ I do not know ☐
• Kidney problems	Yes ☐ No ☐ I do not know ☐	Yes ☐ No ☐ I do not know ☐
• Pulmonary problems	Yes ☐ No ☐ I do not know ☐	Yes ☐ No ☐ I do not know ☐
• Liver problems	Yes ☐ No ☐ I do not know ☐	Yes ☐ No ☐ I do not know ☐
• Other	Yes ☐ No ☐ I do not know ☐	Yes ☐ No ☐ I do not know ☐

- Are you currently on any medication prescribed by a doctor..... Yes ☐ No ☐ I do not know ☐
  or purchased without a prescription ? ..... Yes ☐ No ☐ I do not know ☐
- Have you ever taken any medication over a long period of time ? ..... Yes ☐ No ☐ I do not know ☐
- Do you have any allergies ? (including to medication) ..... Yes ☐ No ☐ I do not know ☐

Your last eye examination

- When was your last eye examination ?..... _____
- Was it done at theMontreal School of Optometry Clinic ?..... : Yes ☐ No ☐ I do not know ☐

If not... were you examined by...

an ophthalmologist ☐ an optometrist ☐ screening ☐

PF 12-07-96

Clinique universitaire de la vision

Université de Montréal

CLINIQUE GÉNÉRALE

Histoire de cas

Sphère	Cylindre	Axe	Prisme	E.O.

Add	Hauteur	D1

RX 1 : _____

Date : _____

Sphère	Cylindre	Axe	Prisme	E.O.

Add	Hauteur	D1

RX 2 : _____

Date : _____

Sphère	Cylindre	Axe	Prisme	E.O.

Add	Hauteur	D1

RX 3 : _____

Date : _____

Diagnostic

Plan de traitement / Recommandations

Prescription finale		Addition	Vertex	E.O.	Prisme	D1
OD						
OS						
Matériau		Teinte		Segment		

Nom de l'étudiant (e) : _____

Signature : _____

Nom de l'optométriste : _____

Signature : _____

Acuité visuelle			Échelle d'optotype : _____		
A.V.	Sans correction		Avec correction ☐ Lunettes ☐ LC		Trou sténopéique
	VL	VP	VL	VP	VL
OD	6/	.40 /	6/	.40/	6/
OS	6/	.40 /	6/	.40/	6/
OU	6/	.40 /	6/	.40/	6/

Kératométrie

OD : _____ X _____ @ _____

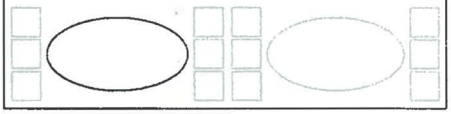
OS : _____ X _____ @ _____

Mires : ☐ *Floues* ☐ *Déformées*

Tests préliminaires		Tests	VL ☐ avec RX	VP ☐ avec RX
Alignement oculaire	*Objectif*	*Test écran*		
	Subjectif	☐ *P. Vertical* ☐ *T. Maddox*		
Fusion sensorielle	*Non stéréoscopique*	☐ *FR* ☐ *Worth*		
	Stéréoscopie	☐ *Randot* ☐ *Mouche* ☐ *Autre*		
PRC ____ / ____ cm		*Amplitude accommodation*		

Mouvements oculaires

☐ Souples ☐ Complets œil fixateur : _____



Réflexes pupillaires

OD : mm ____ lt MG(+ / -)

OS : mm ____ lt MG(+ / -)

Vision des couleurs

OD : _____ OS : _____

☐ Ishihara ☐ D-15 ☐ D-15 désaturé

Réfraction		Étudiant	Clinicien
Rétinoscopie Objective	**Statique**	OD OS	OD OS
	Indra Mohindra	OD OS	OD OS
	Sous cycloplégie	OD OS	OD OS
Réfraction Subjective	**Maximum convexe**	OD 6/ OS 6/	OD 6/ OS 6/
	MAV	OD 6/ 6/ OS 6/	OD 6/ 6/ OS 6/
	MAV sous cycloplégie	OD 6/ 6/ OS 6/	OD 6/ 6/ OS 6/
	Acceptation de convexe	OD Net : ____ OS	OD Net : ____ OS
	ARN/ARP	_____ / _____ @ 40 cm	Lentilles de départ ☐ MAV
	Add. finale : + _____	Zone de vision claire : _____ cm @ _____ cm	☐ AV .40/.37 ☐ _____ / _____

Déviations oculaires	VL Lentilles : ☐ MAV ☐ Correction		VP Lentilles : ☐ MAV ☐ Correction	
Déviation subjective	*H :*	*V :*	*H :*	*V :*
Amp. fusionnelle horizontale	*BI :*	*BE :*	*BI :*	*BE :*
Amp. fusionnelle verticale	BH_{OD} :	BH_{OS} :	BH_{OD} :	BH_{OS} :

Médicaments

Gtt	%	Médicaments actifs	Heure
		Proparacaine	
		Tropicamide	
		Phénylèphrine	
		Cyclopentolate	

Première dilatation pupillaire ☐ OUI ☐ NON

Patient avisé du flou et de la dilatation ☐ OUI ☐ NON

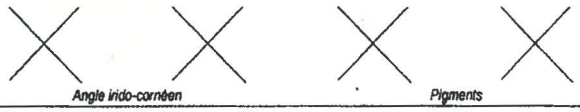
Tonométrie

OD : _____ OS : _____ (h) ☐ Goldmann ☐ Perkins ☐ Tonopen ☐ NCT

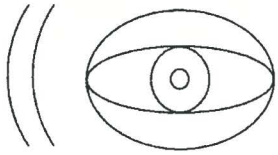
OD : _____ OS : _____ (h) ☐ Goldmann ☐ Perkins ☐ Tonopen ☐ NCT

Pachymétrie : OD _____ ajust. ( ) OS _____ ajust. ( )

Gonioscopie



Segment antérieur



Paupière

Conjonctive palpébrale

Conjonctive bulbaire

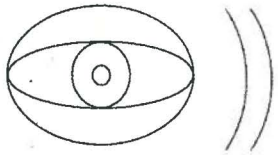
Cornée

Chambre antérieure

Iris

Cristallin

BUT



Segment postérieur

☐ Ophtalmoscopie ☐ Biomicroscopie du fond d'oeil

Milieux

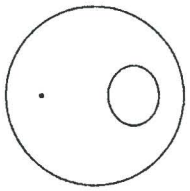
Papilles (bord , couleur)

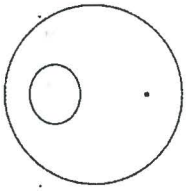
Ratio E/P (H/V) Profondeur

PVS

Rapport A/V - RAL

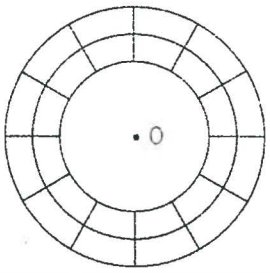
Aire maculaire (apparence- RF)

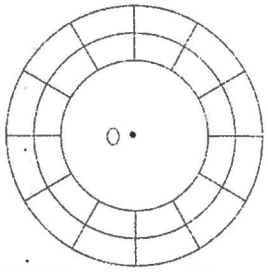




Rétine périphérique

☐ B.I.O., ☐ Lentille à 3 miroirs





WELCOME TO THE OPTOMETRIC CENTER OF LOS ANGELES

Please Print

Date:_____

Patient's Name:_____ SSN:_____ Date of Birth:_____
Last First Middle

Address:_____ Hm. Tel.:( ) _____ Bus.Tel.:( ) _____
Number & Street City Zip

Sex: M F Marital Status:_____Driver's Lic. #_____E-Mail:_____

Optional-Race/Nationality: Hispanic/Latino____ African American_____ Asian____ Caucasian____ Other:_____
Emergency Contact: Name_____Relation_____Phone _____
Were you referred to our clinic? Yes No If yes, by whom:_____
Do you have insurance or other managed care plans? Yes No Name of plan:_____

Please provide Account Responsible Information or if a minor Parent/Guardian information below

Account Responsible Name:_____ Rel. to Patient _____
Last First Middle

Address:_____ Hm. Tel.:( ) _____ Cell Tel:( ) _____
Number & Street City Zip

Work Address:_____ Bus. Tel.:( ) _____ Extension:____
Number & Street City Zip

Sex: M F Marital Status:_____ SSN:_____ Date of Birth:_____ Driver's Lic ID #_____

Authorization to treat minor (if patient is under 18 years): I authorize the Optometric Center of Los Angeles to provide diagnostic and treatment services as appropriate and necessary for this child under the general supervision of any staff optometrist. This consent is given pursuant to the provisions of Section 25.8 of the Civil Code of California.
Parent/Guardian Signature: _____ **Relation** _____ **Date**_____

1. Reason for your visit: _____
2. Approximately when was your last vision examination? _____ Dr.'s name _____
3. When was your last physical examination by a physician? _____Dr.'s name_____
4. Have you ever worn glasses? Yes No When?_____ Have you worn contact lenses? Yes No When? _____
5. Have you experienced any of the following eye/vision problems? (Check all that apply and describe)

___Itchy eyes	___Watery eyes	___Double vision	___Cataracts
___Pain/Soreness	___Discharge	___Loss of vision	___Glaucoma
___Red eye	___Tired eyes	___Flashes of light/Floaters	___Macular degeneration
___Burning/Stinging	___Light Sensitivity	___Eye injury	___Crossed eye/lazy eye
___Dryness/sandy/gritty	___Blurred vision	___Eye surgery	___Other_____

6. Have you ever had any of the following conditions?

___Headaches	___Respiratory problems	___High cholesterol	___Thyroid/other gland
___Seizures	___Tuberculosis	___Cancer	___Arthritis/ Muscle/joint pain
___Allergies/hay fever	___Diabetes	___Psychiatric condition	___Skin condition
___Sinus	___Heart problems	___Uro-genital condition	___Anemia/bleeding
___Dry throat/mouth	___High blood pressure	___Kidney/Bladder	___Other _____

7. Are you a smoker? Yes No Do you use recreational drugs? Yes No Do you drink alcoholic beverages? Yes No
8. Do you have any other eye or vision problem (other than glasses) or other health problem not checked above? Explain _____
9. Is there anyone in your immediate family with any of the above conditions? Explain_____
10. If you have diabetes, when was it diagnosed? _____ Date of last blood sugar test and sugar level? _____
11. Have you ever had a Tuberculosis (TB) test? Yes No If so, was your test positive? Yes No
    Have you ever had a positive chest x-ray for TB? Yes No Have you ever had treatment for TB? Yes No
12. Have you ever had an allergic reaction to any medication or anesthesias? Yes No
    If so, which ones? _____
13. List any medications you are currently taking and for what reasons: _____

I authorize payment of Medicare benefits or other insurance be made to the Optometric Center of Los Angeles for any services furnished. I further authorize the Optometric Center to release any medical information necessary to my insurance company to determine benefits and to process claims submitted on my behalf or for my dependents. I understand that I am financially responsible to the Optometric Center for all charges not covered by my insurance as well as any deductible and/or coinsurance. If I use an insurance carrier not connected with the Center, I will submit the billing directly to the insurance company. **I understand that all payments are required to be made at time of service.**

Date _____ Patient Signature_____

Name of Parent or Legal Guardian (if patient is a minor): _____

Thank you

BIENVENIDO AL CENTRO OPTOMETRICO DE LOS ANGELES

Por Favor, use letras de molde.

Fecha: _____

Nombre del Paciente: _____ Seguro Social #: _____
Apellido Primer Nombre Segundo Nombre

Dirección: _____ Tel. Casa: (___) _____ Tel. Trabajo: (___) _____
Calle y Numero Ciudad Codigo Postal

Sexo: Masc Fem Estado Civil: _____ Licensia de manejar/ID # _____ Fecha de Nacimiento: _____

Informacion Opcional: Raza/Nacionalida: Hispano/Latino___ Africano Americano___ Asiatico___ Blanco___ Otro: _____
Contacto de Emergencia: Nombre _____ Relacion al Paciente _____ Telefono _____
¿Fue Ud. Recomendado a esta Clinica? Si No ¿Por quien? _____
¿Tiene usted Aseguranza u otros planes de salud? Si No Nombre del Plan _____

Por favor de dar informacion sobre el Responsable o si el paciente es menor de edad informacion sobre el padre/ guardian.

Nombre del Responsable: _____ Relacion al Paciente: _____
Last First Middle

Dirección: _____ Tel. Casa: (___) _____ Celular: (___) _____
Calle y Numero Ciudad Codigo Postal

Dirección de Trabajo: _____ Tel. Trabajo: (___) _____ ext. _____
Calle y Numero Ciudad Codigo Postal

Sexo: Masc Fem Estado Civil: _____ Seguro Social # _____ Fecha de Nacimiento: _____

Autorización de tratar a menor de edad (si el paciente es menos de 18 años): Autorizo el Centro Optometrico de Los Ángeles para proporcionar servicios del diagnóstico y del tratamiento como apropiados y necesarios para este niño bajo supervisión general del doctor optómetrico. Este consentimiento se da conforme a las provisiones de la sección 25.8 del Código Civil de California.
Nombre del Padre o Guardian: _____ **Relacion** _____ **Fecha** _____

1. Razón de la visita: _____
2. ¿Aproximadamente, cuándo fué su último examen de la vista? _____ Nobre del Dr. _____
3. ¿Cuándo fué su último examen físico por un medico? _____ Nombre del Dr. _____
4. ¿Ha usado anteojos? Si No ¿Cuándo? _____ ¿Ha usado lentes de contacto? Si No ¿Cuándo? _____
5. Indique todos los síntomas o problems de vista o de los ojos que tenga:

___Comezón de los ojos	___Lagrimeo/ojos llorosos	___Vision doble	___Cataratas
___Dolor en los ojos	___Secrecion	___Perdida de vision	___Glaucoma
___Ojos rojos	___Ojos cansados	___Rayos de luce/ Manchas	___Degeneracion de retina
___Ardor/picadura en los ojos	___Sensibilidad a la luz	___Trauma en los ojos	___Ojo perezoso/bizco
___Sequedad/ojos arenoso	___Vision borrosa	___Cirujía de los ojos	___Otros _____

6. ¿Ha tenido alguna de las siguientes enfermedades o problemas?

___Dolores de cabeza	___Problemas de respiracion	___Colesterol alto	___Tiroides/otras glandulas
___Ataques	___Tuberculosis	___Cancer	___Artritis/Dolor de musculos/articulaciones
___Alergias	___Diabetes	___Tratamiento psiquiatrico	___Problemas de piel
___Sinusitis	___Problemas del Corazon	___Problemas uro-genitales	___Anemia/hemorragias
___Boca/garganta seca	___Presion alta	___Riñonas/ vesicula	___Otros _____

7. ¿Fuma usted? Si No ¿Usa Droga? Si No ¿Toma Bebidas Alcoholicas? Si No
8. ¿Tiene usted otros problemas de vista, de los ojos, o de salud que no ha indicado arriba? Explique _____
9. ¿Hay alguien en su familia que tenga una o varias de las condiciones arriba? Explique _____
10. Si tiene la diabetes, ¿cuando fue diagnosticado? ____ Fecha de la ultima prueba del azúcar y nivel de azúcar _____
11. ¿Ha tenido un examen de Tuberculosis? Si No ¿Si sí, era la prueba positiva? Si No
    ¿Ha tenido un Rayo-X positivo de Tuberculosis? Si No ¿Ha tenido tratamiento para Tuberculosis? Si No
12. ¿Ha tenido una reacción alérgica a cualquier medicamento o anestesia? Si No
    ¿A cuales? _____
13. Si está tomando alguna medicina, que medicina(as) es(son) y para qué la(s) está tomando: _____

Solicito que los pagos de beneficios por cualquier servicio prestado, autorizados por Medicare u otras aseguranzas sean hechos en mi favor al Centro Optometrico de Los Angeles. A lo mas, autorizo al Centro Optometrico a liberar informacion medica sobre mi o mis dependientes cuando sea necesario, para establecer los beneficios y pagar por los servicios recibidos. Entiendo que soy financieramente responsable al Centro Optometrico de todas las cargas no cubiertas por mi seguro así como cualquier deducible y/o coinsurance. Si utiiizo un portador de seguro no conectado con el Centro, someteré la facturación directamente a la compañía de seguros. **Entiendo que todos los pagos están requeridos para ser hechos al fin de la consulta.**

Fecha _____ Firma _____
Nombre del Padre o Guardian (si el paciente es menor de edad) _____

GRACIAS

OPTOMETRIC CENTER OF LOS ANGELES

New_____
Estab_____

Comprehensive Vision Exam

FILE #_____

NAME _____ DOB_____ AGE____ M F RACE_____ DATE_____

OCCUPATION_____ AVOCATION_____ PLAN_____

CC (+4 HPI)_____

PEH LEE: ( ) Inj. ( ) Surg. ( )LOV ( ) Glc. ( ) Cat.
( )F/F ( ) Diplopia ( ) Dry eyes ( ) Other:

PMH N9 E1 LPE: ( )HTNx ( ) DMx ( ) Heart ( ) Resp.
( ) E.N.T. ( ) Neuro/ HA ( ) Allergies ( ) Skin ( ) Urogenital
( ) GI ( ) Muscle/join ( ) Thyroid ( ) Other

FEH ( ) Blind: ( ) Glc. FMH ( ) DM ( ) HTN
( )Other: ( )Other:

Current Medication:_____
Medication Allergies:_____
Smoking / Alcohol / Drug use:

VA	Dist		Near		CT 6M cc/sc _____	Fusion	Pupils: P RRL ( )APD
	SC	CC	SC	CC	40cm cc/sc _____		K S MIRES
OD					versions_____		OD F @
OS					confront_____	NPC	K S MIRES
OU					stereo		OS F @

Pinhole:	Color Vision:	BP / at

HAB	R	ADD +	Type	HAB	R	ADD+	Type
Rx#	L	ADD +		Rx#	L	ADD+	

RET OD	SUBJ OD	20/	PD
OS	OS	20/ OU 20/	

Distance:	Thru: _____	Near thru:	NRA PRA
L Ph_____V Ph _____	BX Cyl:_____	L Ph: V Ph :	AMP / /
BI_____ L BU_____	Near OD_____	BI: L BU :	Range / thru /
BO L BD	VA OS_____ OU	BO: L BD :	

Presence of Neurological Conditions-No Yes Mood/Effect/Orientation-Normal Abnormal

Additional Tests /Obs:

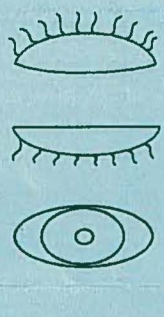
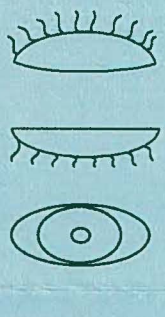
TENTATIVE SRx (TRIAL FRAMED):

	SPH	CYL	AXIS	ADD	PRISM	DVA	NVA	TRIAL FRAMED
R								
L								

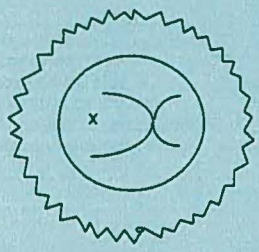
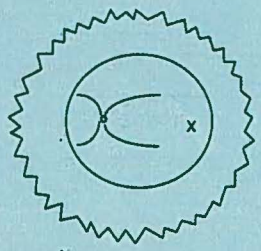
FINAL SRx:

	SPH	CYL	AXIS	ADD	PRISM	TYPE	DVA	NVA	USE
R									
L									

GAT NCT IOP at:	VISUAL FIELDS: Instrument/Field Program
FLURESS/FLUROX/FLURON (CIRCLE ONE)	Results:
OD OS	

OD	ANTERIOR SEGMENT	OS
	LIDS LASHES CONJ. CORNEA AC ANGLE IRIS LENS VITREOUS TBUT TEAR MENISCUS	

DPAs	☐Tropicamide 1% _____gtt_____AM/PM ☐ Paramyd ____gtt____AM/PM ☐Phenylephrine 2.5% _____gtt_____AM/PM ☐Other:	☐DO☐BIO☐78D/90D

OD	FUNDUS	OS
	MEDIA ONH MARGINS RIM TISSUE CRVP X CD X RNFL VESSELS MACULA BACKGROUND PERIPHERY	

WORKING PROBLEM LIST/ASSESSMENT	PLAN (Dx;Tx;pt ed) Circle one: DFE pt ed/DFE pamphlet
INTERN (legible):	FACULTY (legible):
PRINT NAME:	PRINT NAME: Recall:
DATE:	DATE:

/data/admin/forms/hallway/02.comp

University of Waterloo
School of Optometry

File No. _____ **Full Oculo/Visual Assessment Record** Date _____

PATIENT IDENTIFICATION

Name _____ (SURNAME / GIVEN NAMES) Tel.No. _____ (HOME / BUSINESS)

Birth Date _____ (DAY / MONTH / YEAR) Age _____ M ☐ F ☐ Occupation _____

Family Physician _____ Visual Demands/Avocation _____

Last Eye Exam _____ Today's exam OHIP covered? Yes ☐ No ☐ Drivers Licence Rest. Yes ☐ No ☐

CASE HISTORY

Reason for visit:

Present Rx D.B.C. /

	SPH	CYL	AXIS	PRISM	ADD	OTHER
O.D.						
O.S.						

Medical Care and LME (reason)

Blur
Diplopia
Flashes/Floaters
Haloes
Asthenopia
HA
Pain/Itching
Eye Injury/Infection
Eye Surgery
Strab
Age of Spectacles
Use of spectacles
CL
Additional Information

Allergies: No ☐ Yes ☐
Smoker: No ☐ Yes ☐
When quit:
Medications/Supplements

Family History
DM
HPT
Glaucoma
RD
Strab
Blindness
Other

PRELIMINARY TESTING

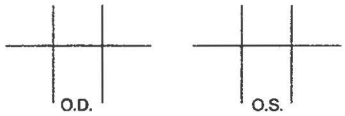
Unaided V.A. (Dist.) O.D. _____ O.S. _____ O.U. _____ (Near) _____ cms. O.D. _____ O.S. _____ O.U. _____

Aided V.A. (Dist.) Spectacles ☐ CL ☐ O.D. _____ O.S. _____ O.U. _____ (Near) _____ cms. O.D. _____ O.S. _____ O.U. _____

Amp. of Accom. (Push Up) O.D. _____ D O.S. _____ D N.P.C. _____ cms. PD _____ / _____

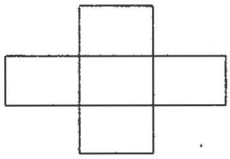
COVER TEST:
Unilateral (Dist.) (Near cms.)
Alternating (Dist.) (Near cms.)

Ocular Motility:
Saccades _____
Pursuits _____
Gaze Restrictions: Unrestricted

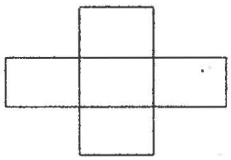


Visual Fields: (Confrontation or Attached Record)

Comitancy
Test: _____
Distance _____



Maddox Rod OD OS
Distance _____
Head tilt R _____
Head tilt L _____



Fusion
Test

Colour Vision
O.D.
O.S.
Test

Stereopsis
Test

OCULAR HEALTH

OD OS

Lens

General Observations _____

	OD	OS
Lid and Margins		
Conjunctiva		
Limbus		
Cornea		
Tear Breakup Time		
Anterior Chamber		
Angle (van Herick)		
Iris		
Pupil Size		
Pupil Reflexes:		
Direct		
Consensual		
Accommodative		
Marcus/Gunn		
Tonometry		

Perkins / Goldmann / NCT Time: _____

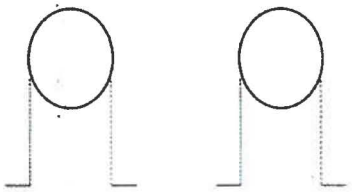
Anesthetic _____ ☐ Informed consent
(type and dosage)

Mydriatic _____ Time: _____
(type and dosage)

☐ Informed consent patient/guardian

Ease of exam: ☐ good view ☐ other _____

Disc:



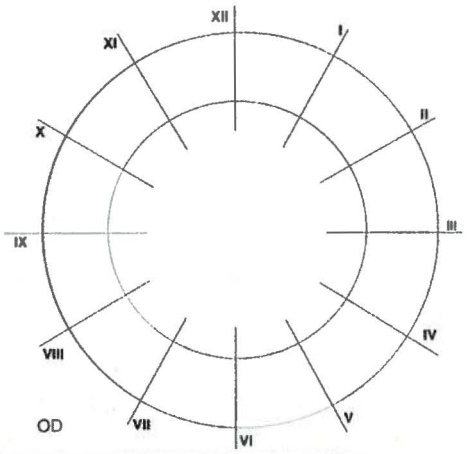
Cup Profile:

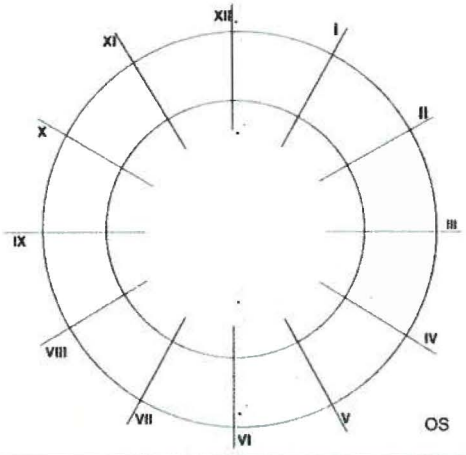
		OD	OS
C/D Ratio	H		
	V		
Colour			
Margin			
Lamina Cribrosa			
Macula			
Retinal Vessels:			
Calibre/Ratio			
A/V Crossings			
Course			
Periphery			
Vitreous			

Intern: ☐ BIO ☐ Fundus biomicroscopy ☐ MIO ☐ Direct

Doctor: ☐ BIO ☐ Fundus biomicroscopy ☐ MIO ☐ Direct

FUNDUS





DO NOT WRITE IN THIS SPACE

REFRACTION

Keratometry O.D. _____ / _____ Corneal _____ X _____

O.S. _____ / _____ Cylinder _____ X _____

Comments

Static Retinoscopy

O.D. _____ VA _____

O.S. _____ VA _____

Subjective Refraction: Phoropter / Trial Frame

O.D. _____ VA _____

O.S. _____ VA _____

Other Prism / RG Balance

O.D. _____ VA _____

O.S. _____ VA _____

VA _____

BINOCULAR VISION

Von Graefe / Free Space

6M					40CM				
Phoria	Diss Lat	_____	Vert	_____	Phoria	Diss Lat	_____	Vert	_____
Neg. Fus.	Vergence	_____	+V.V. $^{BU}/_{OS}$	_____	Neg. Fus.	Vergence	_____	+V.V. $^{BU}/_{OS}$	_____
Pos. Fus.	Vergence	_____	−V.V. $^{BO}/_{OS}$	_____	Pos. Fus.	Vergence	_____	−V.V. $^{BO}/_{OS}$	_____

Gradient Phoria +1.00 _____ Accom Facility OD _____ Ampl of Accom OD _____

ACA _____/1_____ ± _____ D OS _____ (Sheard's) OS _____

ADD

Crosscyl/Age/Sheard's OD _____ VA _____ BMA _____ Final _____ Range from _____ cm

Habitual WD _____ cm OS _____ VA _____ BPA _____ Add _____ to _____ cm

ADDITIONAL TESTS

Trial Framed Tentative Rx ☐

SUMMARY

#	Problem	#	Plan

BILLING

OHIP

V404 ☐ V402 ☐ V409 ☐ Code _____ V408VF ☐

V406 ☐ V408 ☐ Code _____ V402VF ☐

Private billing:

Full OVA ☐ Emergency exam ☐

Partial OVA ☐ Other (specify) _____

FOLLOW UP APPT.

Follow up appointment booked: (circle) Clinic area: PC OH BV PSN LV ED CL Date/Time _____

For appointments within a few months.

RECALL

Recall: 3 mo. 6 mo. 1 yr. 2 yr. none unchanged Other: _____ for Full/Partial examination ☐ Entered (staff use)

(only to PC, by card or telephone call)

Reason _____

PRESCRIPTION

	SPH.	CYL.	AXIS	PRISM	ADD
O.D.					
O.S.					

Additional Specifications:

Valid for: 6 mo. 1 yr. 2 yr. other _____ Doctor's Initial for Prescription _____

Note: The prescription should be completed if the patient wears spectacles or could wear spectacles. If a prescription could not be determined or if there is no prescription it should be struck through.

_____ Intern's Name (Printed)

_____ Doctor's Name (Printed by Doctor on File Approval)

OPT. DEC. 2005 6394

Confidential Medical History **Date:**

Name: _____ Date of Birth: _____ ☐ Male ☐ Female
Address: _____ Phone: _____
_____ Social Security #: _____
Name of Medical Doctor: _____ Dr.'s Phone #: _____

List any allergies to medicines: _____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Are you pregnant or nursing? ☐ Yes ☐ No

Do you wear glasses? ☐ Yes ☐ No If yes, how old are your lenses? _____

Do you wear contact lenses? ☐ Yes ☐ No If yes, how old is your current pair? _____

What type of contact lenses: ☐ Disposable Soft Lenses ☐ Standard Soft Lenses ☐ Rigid

If you use disposable lenses how often do you throw them away? _____

What solutions do you use? _____Do you ever sleep in your lenses? ☐ Yes ☐ No

Personal/Family History
Please answer the questions below regarding you or your immediate family (parents, grandparents, siblings, children) for the following:

	You		Family			
	Yes	No	Yes	No	?	How are they related to you?
Blindness/Loss of Vision	☐	☐	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	☐	☐	_____
Glaucoma	☐	☐	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	☐	☐	_____
Retinal Detachment	☐	☐	☐	☐	☐	_____
Retinal Disease	☐	☐	☐	☐	☐	_____
Cancer	☐	☐	☐	☐	☐	_____
Diabetes	☐	☐	☐	☐	☐	_____
Heart Disease	☐	☐	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	☐	☐	_____
Lupus	☐	☐	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	☐	☐	_____
Other _____	☐	☐	☐	☐	☐	_____

Tang Eye Center

Social History (If you feel uncomfortable answering these questions here, please feel free to skip this section and discuss these areas directly with your clinician.)

Do you drive? ☐ Yes ☐ No If yes, do you have difficulty with vision while driving? ☐ Yes ☐ No

Do you use tobacco products? ☐ Yes ☐ No If yes, type/amount/how long: _____

Do you drink alcohol? ☐ Yes ☐ No If yes, type/amount/how long: _____

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

	Yes	No	?		Yes	No	?
Constitutional				***Ears/Nose, Mouth, Throat***			
Fever/Weight Changes	☐	☐	☐	Allergies/Hay Fever	☐	☐	☐
Integumentary (Skin)	☐	☐	☐	Sinus Congestion	☐	☐	☐
Rosacea	☐	☐	☐	Dry Throat/Mouth	☐	☐	☐
Neurological				***Respiratory***			
Headaches	☐	☐	☐	Asthma	☐	☐	☐
Migraines	☐	☐	☐	Emphysema	☐	☐	☐
Seizures	☐	☐	☐	Chronic Bronchitis	☐	☐	☐
Eyes				***Vascular/Cardiovascular***			
Blurred Vision	☐	☐	☐	Diabetes	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐	Vascular Disease	☐	☐	☐
Loss of Side Vision	☐	☐	☐	High Cholesterol	☐	☐	☐
Double Vision	☐	☐	☐	High Blood Pressure	☐	☐	☐
Dryness	☐	☐	☐	***Gastrointestinal***			
Mucous Discharge	☐	☐	☐	Chronic Diarrhea	☐	☐	☐
Redness	☐	☐	☐	***Genitourinary***			
Sandy or Gritty Feeling	☐	☐	☐	Kidney/Bladder	☐	☐	☐
Itching	☐	☐	☐	***Bones/Joints/Muscles***			
Burning	☐	☐	☐	Rheumatoid Arthritis	☐	☐	☐
Foreign Body Sensation	☐	☐	☐	***Lymphatic/Hematologic***			
Glare/Light Sensitivity	☐	☐	☐	Anemia	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐	Bleeding Problems	☐	☐	☐
Styes	☐	☐	☐	***Endocrine***			
Flashes/Floaters in Vision	☐	☐	☐	Thyroid	☐	☐	☐
Tired Eyes	☐	☐	☐	***Psychiatric***	☐	☐	☐
				Other	☐	☐	☐

Have you ever had refractive surgery? ☐ Yes ☐ No If yes, specify type: ☐ RK ☐ PRK ☐ LASIK

Are you interested in laser surgery? ☐ Yes ☐ No

Clinician: _____ Attending: _____ Date: _____

Tang Eye Center

Eye Examination ***Date:***

Name: DOB: Last Exam: Last Rx:
Clinician:
CC:

History of Present Illness: All:

* Meds:

*

*

*

Medical History & ROS reviewed: ☐Y ☐N Psych: Mood/Affect (anxiety/agitation/depression) ☐ nl Neuro: Oriented (person/time/place) ☐Y ☐N

W:	20/	SOR:	20/	***CL Hx/Fitting on Back***
	20/		20/	Additional Tests
R:	20/	DCT		
	20/	NCT		
M:	20/	NPA/NPC		
	20/	PD		
B:	20/	Pupils		
	20/	EOM		
Rx:		VF		

0.5% T, 1% T, 2.5% P

A, P, NCT T

Adnexa	C/D	☐ Indent
L/L	Rim	☐ 20D
Bul Conj	Margins	☐ 90D
Pal Conj	FR	☐ 78D
Cornea	Macula	☐ 60D
A/C	Vessels	☐ 3 Mirror
Iris	Periphery	
Lens		
Vitreous		

A:

P:

Intern: _____ Attending: _____

Tang Eye Center

Social History (If you feel uncomfortable answering these questions here, please feel free to skip this section and discuss these areas directly with your clinician.)

Do you drive? ☐ Yes ☐ No If yes, do you have difficulty with vision while driving? ☐ Yes ☐ No

Do you use tobacco products? ☐ Yes ☐ No If yes, type/amount/how long: _____

Do you drink alcohol? ☐ Yes ☐ No If yes, type/amount/how long: _____

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

	Yes	No	?		Yes	No	?
Constitutional				***Ears/Nose, Mouth, Throat***			
Fever/Weight Changes	☐	☐	☐	Allergies/Hay Fever	☐	☐	☐
Integumentary (Skin)	☐	☐	☐	Sinus Congestion	☐	☐	☐
Rosacea	☐	☐	☐	Dry Throat/Mouth	☐	☐	☐
Neurological				***Respiratory***			
Headaches	☐	☐	☐	Asthma	☐	☐	☐
Migraines	☐	☐	☐	Emphysema	☐	☐	☐
Seizures	☐	☐	☐	Chronic Bronchitis	☐	☐	☐
Eyes				***Vascular/Cardiovascular***			
Blurred Vision	☐	☐	☐	Diabetes	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐	Vascular Disease	☐	☐	☐
Loss of Side Vision	☐	☐	☐	High Cholesterol	☐	☐	☐
Double Vision	☐	☐	☐	High Blood Pressure	☐	☐	☐
Dryness	☐	☐	☐	***Gastrointestinal***			
Mucous Discharge	☐	☐	☐	Chronic Diarrhea	☐	☐	☐
Redness	☐	☐	☐	***Genitourinary***			
Sandy or Gritty Feeling	☐	☐	☐	Kidney/Bladder	☐	☐	☐
Itching	☐	☐	☐	***Bones/Joints/Muscles***			
Burning	☐	☐	☐	Rheumatoid Arthritis	☐	☐	☐
Foreign Body Sensation	☐	☐	☐	***Lymphatic/Hematologic***			
Glare/Light Sensitivity	☐	☐	☐	Anemia	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐	Bleeding Problems	☐	☐	☐
Styes	☐	☐	☐	***Endocrine***			
Flashes/Floaters in Vision	☐	☐	☐	Thyroid	☐	☐	☐
Tired Eyes	☐	☐	☐	***Psychiatric***	☐	☐	☐
				Other	☐	☐	☐

Have you ever had refractive surgery? ☐ Yes ☐ No If yes, specify type: ☐ RK ☐ PRK ☐ LASIK

Are you interested in laser surgery? ☐ Yes ☐ No

Clinician: _____ Attending: _____ Date: _____

Tang Eye Center

ICO FORMS

ILLINOIS EYE INSTITUTE
3241 S. Michigan Avenue
Chicago, Illinois 60616
(312) 225-6200

Name _____ Date _____
Address _____ File # _____
_____ Suite _____
DOB __/__/__ Age ___
_____ Race/Gender
Phone _____

Patient History:

Lensometry:

	SPH	CYL	AXIS	PRISM	ADD	SEG
OD						
OS						

☐ patient exhibits normal affect and orientation
ROS dated _____ reviewed by _____

Ocular med:	dose	eye	last

key elements of history and chief complaint have been rechecked and verified _____

sc V

	20 ft	16 in
OD		
OS		
OU		

cc V

	20 ft	16 in
OD		
OS		
OU		

	20 ft
V PH	

C.F. OS OD

Cover test Dist _____ Near _____ Thru _____

Pupils _____ PD _____

EOMs _____ Stereo _____

Color OD _____ OS _____ Test _____

Keratometry
Auto/Man OD _____ @ _____
OS _____ @ _____

Retinoscopy
OD _____ _____
OS _____ V _____

Manifest
OD _____ _____
OS _____ V _____

Binocular
OD _____ V _____
OS _____
OU _____

ACCOM / BINOCULAR STATUS
Thru _____

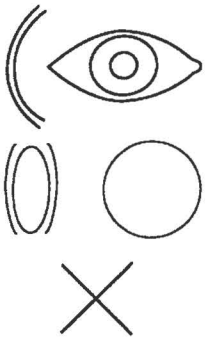
Near add _____ VA _____ Range _____
Near phoria Lat _____ Vert _____ Method _____
Near vergence BI ___/___/___ BO ___/___/___ ___
NRA +_____ PRA — _____ @ _____
Amplitude OD _____ OS _____ Method _____

ADDITIONAL TESTING

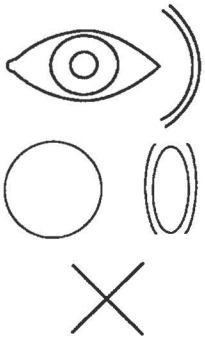
Final SRx OD _____ 20/___
OS _____ 20/___
add _____

PC_CompExam_0905

BIOMICROSCOPY



Adnexa / Orbit
Eyelids / Lashes
Conjunctiva
Sclera
Cornea
TBUT
Angle
AC
Iris
Lens



Diagnostic Agents @ _____

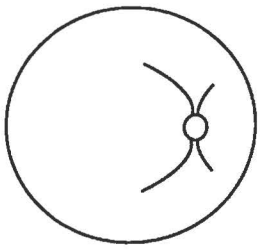
- ☐ Informed consent given for diagnostic agents
- ☐ Side effects of DPA's explained (near blur, photophobia, mydriasis)
- ☐ + gt Proparacaine OU
- ☐ + gt Fluress OU
- ☐ + gt 1% Tropicamide OU
- ☐ + gt 2.5% Phenylephrine OU
- ☐ + gt 1% Cyclopentolate OU

Blood pressure _____

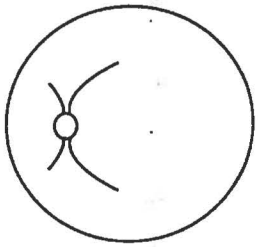
T_A ___ <

Anterior segment exam performed / verified:

OPHTHALMOSCOPY



Cup / Disc H&V
Color
Margins
Vessels
Venous Pulse
Macular Area
Vitreous
Periphery



Posterior segment exam performed / verified:

MEDICAL DECISION MAKING:

Assessment:

Plan / Pt ed:

Return _____ for:

- ☐ Comprehensive
- ☐ DFE
- ☐ IOP / Med check
- ☐ Visual field
- ☐ Follow up
- ☐ Rx check
- ☐ CLPR
- ☐ Referral _____

- ☐ Patient aware of condition and follow up care.
- ☐ Pt ed risk, benefit, tx, mgmt of condition.
- ☐ Business / appt card given.
- ☐ _____

Student: _____ Attending Staff: _____

PC_CompExam_0905

Medical History Interview

To comply with medical record requirements, please complete the following information.

Name_____ Today's date_____

Address_____ Date of Birth_____

_____ Occupation_____

Phone_____ Hobbies_____

Name of Primary Medical Doctor_____

Last Medical Exam_____ Last Eye Exam_____

What is your reason for today's eye exam? Please mark all that apply.

_____blur at distance	_____glaucoma	_____eye pain/discomfort
_____blur at near	_____lazy eye	_____itching
_____double vision	_____red eyes	_____broken glasses
_____computer strain	_____flashes/spots	_____contact lenses
_____headache	_____tears/discharge	_____other

Have you had an eye injury? __no__yes If yes, explain:_____

Have you had eye surgery? __no__yes If yes, explain:_____

How old are your current glasses?_____

How old are your current contact lenses?_____

What type of contacts do you wear? __hard __soft __disposable __other

Medical History

Do you have, or have you ever been treated for:

_____diabetes (high sugar)	_____arthritis/joint pain	_____breathing problems
_____high blood pressure	_____kidney/urinary	_____depression/anxiety
_____heart disease	_____STD	_____sinus/allergy
_____stroke	_____cancer	_____skin condition
_____stomach problems	_____HIV	_____hearing loss
_____thyroid/glands	_____headache	_____other_____

Do you take any medications? __no__yes If yes, list:_____

_____

Do you have any allergies? __no__yes If yes, explain:_____

Are you now pregnant? __no__yes

Do you smoke? __no__yes How much?_____

Do you drink alcohol? __no__yes How much?_____

Do you have a history of recreational drug use? __no__yes

Please mark the people in your family who have the following medical problems:

_____diabetes	_____high blood pressure	_____heart disease
_____arthritis	_____sickle cell disease	_____retinal disease
_____glaucoma	_____macular degeneration	_____crossed eyes
_____blindness		_____other

This side is to be completed for school-aged children only.

Patient Birth and Development History

To the Parent (or Guardian): Information about your child's general health and development is essential in our care of your child. Please complete the questions that follow:

Patient's name:_____
School name:_____ Grade level: _____
Form completed by: _____Relationship to child: _____

Does the child have a hearing problem? ____yes ____no
Does the child have a speech problem? ____yes ____no
Is there a problem with attention or discipline? ____yes ____no

Has the child ever received the following services?

	Yes	No	If yes, please explain
Speech therapy	____	____	_____
Occupational therapy	____	____	_____
Physical therapy	____	____	_____
Developmental therapy	____	____	_____

Education: Please check any of the following that are true about your child's performance:
____School suggests testing to rule out vision problems causing academic problems
____Errors in copying from blackboard to paper
____Avoids near work (reading/writing), or fails to complete work in allotted time
____Poor reading comprehension
____Reads below grade level
____Tilts or turns head excessively during visual tasks
____School performance not up to potential
____Poor handwriting/printing
____Poor spelling ability
____Reverses letters when reading or writing

When reading, does the child:
____Confuse similar words
____Use finger or marker to keep place
____Often lose place, skip, or reread words or letters
____Complain of blurred vision
____Complain of headaches
____Complain of print "running together" or "moving around"
____Says eyes hurt, burn, or tire

Has the child had special education testing or received tutoring services? ____yes ____no
Has the child had an IEP (individual education plan) established? ____yes ____no

Best school subject: _____ Worst school subject:_____
Have there been consultations with doctors or specialists (i.e. neurologists, psychologists) with reference to schoolwork? ____yes ____no
If yes, please discuss_____
Have any other family members had academic or school-related problems? ____yes ____no
If yes, please discuss_____

ILLINOIS EYE INSTITUTE

Primary Eyecare

Date _____

File #_____

3241 South Michigan Avenue
Chicago, Illinois 60616
(312) 225-6200

Name _____ DOB ___/___/___ Age ____ Gender ____

Address _____ Zip_____ Phone _____

Present Dx:	Reason for visit:	Last visit:
Chief Complaint:		
POHx:		
PMHX:		

	New	Est
Brief (1-3)	1,2	2,3
Ext (4+)	3,4,5	4,5

___ Location
___ Quality
___ Severity
___ Duration
___ Time
___ Context
___ Mod Factors
___ Assoc. S/S

Ocular meds:	dose	eye	last

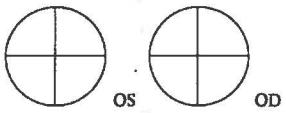
Key elements of history and chief complaint have been rechecked and verified _____
Patient exhibits normal affect and orientation _____
History: Problem focused _____ Expanded problem focused _____ Detailed _____ Comprehensive _____

$V_A <$
cc / sc

Pupils:

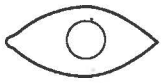
EOMs:

CF:



CL FIT

L/L
CONJ
SCLERA
CORNEA
ANGLE
AC
IRIS
LENS



CL FIT

T_A ___ <

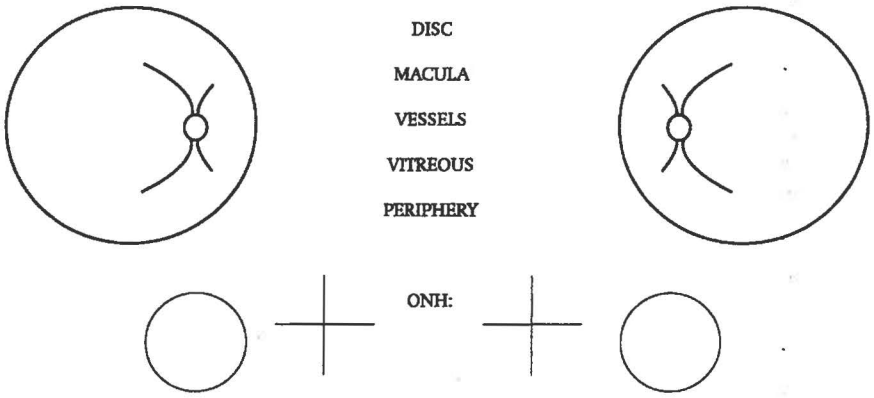
BP/Pulse:

Anterior segment exam performed / verified _____

DPAs: Fluress __
Proparacaine __
Time: Tropic. 1.0% __
Phenyl 2.5% __
Informed consent obtained __
Side effects explained __

PC_FollowUp_0905

Fundus:



Posterior segment exam performed / verified _____

Physical Exam: Problem focused(1-5) _____ Expanded(6-9) _____ Detailed(10-12) _____ Comprehensive(14) _____

Other tests:

Assessment

Plan:

Medical Decision Making (# of diagnoses): Straightforward (1) ____ Low (2) ____ Moderate(3) ____ High (4) ____

Education:

☐ R/B, Tx plan discussed
☐ Importance of follow up
☐ Glaucoma is blinding ds.
☐ Instruct, SE of eye meds
☐ _____

☐ Contact lens wear and care
☐ Contact lenses dispensed:
OD _____
OS _____

Next Appointment:
Date:_____
Time:_____
☐ ER/Business card given

_____ Student

_____ Attending Staff

ICO FORMS

Atwater Eye Care Center
Indiana University School of Optometry
800 East Atwater Avenue, Bloomington, IN 47405
Phone (812) 855-8436 Fax (812) 855-1683

Patient Medical History Record

In an effort to better serve you, we ask that you complete this survey as accurately as possible. Please answer all questions. Thank you.

Today's Date: ____/____/____

Name: _____ **Date of Birth:** ____/____/____

Occupation: _____ **Medical Doctor:** _____

Allergies: List all known allergies.

Penicillin: Yes ☐ No ☐ Sulfa: Yes ☐ No ☐ Iodine: Yes ☐ No ☐ Seasonal allergies: Yes ☐ No ☐

Pain med: Yes ☐ No ☐ Type: _____ Other (please list): _____

Medications: Please list below (or provide a list of) all medications, including eye drops & non-prescription drugs.

_____

_____

Review of Systems:

Do you currently have any of the following problems?	Yes	No	If YES, please explain:
Heart Problems (chest pain, irregular heart beat)	☐	☐	
Respiratory Problems (shortness of breath, wheezing, cough)	☐	☐	
Gastrointestinal Problems (heartburn, abdominal pain, diarrhea)	☐	☐	
Urinary Problems (pain or discomfort, blood in urine)	☐	☐	
Skin Problems (rashes, excessive dryness, rosacea)	☐	☐	
Musculoskeletal Problems (muscle aches, joint pain, swollen joints)	☐	☐	
Neurologic Problems (numbness, weakness, headaches, paralysis)	☐	☐	
Psychiatric Problems (depression, anxiety)	☐	☐	
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	
Ear/nose/throat Problems (hearing loss, sinus problems, sore throat)	☐	☐	
Endocrine Problems (diabetes, thyroid problems)	☐	☐	

Eye injury: previously ☐ currently? ☐ explain: _____

Have you or immediate family member (parent, grandparent, sibling) ever had any of the following conditions?

	Self	Family		Self	Family		Self	Family		Self	Family
Cataract	☐	☐	High Blood Pressure	☐	☐	Diabetes	☐	☐	Migraines	☐	☐
Glaucoma	☐	☐	Heart Disease	☐	☐	Asthma	☐	☐	Seizures/Epilepsy	☐	☐
Crossed/Lazy Eye	☐	☐	Stroke	☐	☐	Chronic Bronchitis	☐	☐	Arthritis	☐	☐
Retinal Detachment	☐	☐	Heart arrhythmia	☐	☐	Sinus Problems	☐	☐	Thyroid Disease	☐	☐
Retinal Degeneration	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐	Cancer	☐	☐
Macular Degeneration	☐	☐	Bleeding Problems	☐	☐	HIV/AIDS	☐	☐	Liver disease	☐	☐
Blindness	☐	☐									

Surgeries: List any previous surgeries, including eye surgeries and laser procedures:

_____

_____

Do you smoke? ☐ Yes ☐ No If YES, how much? _____

Do you drink alcohol? ☐ Yes ☐ No If YES, how much? _____

Are you using or have you ever used recreational (including IV) drugs? ☐ Yes ☐ No

Date	Intern's Initials	Doctor's Initials
_____	_____	_____
_____	_____	_____

Patient/Guardian Signature: _____

Patient Account #_____

Today's Date _____

Atwater Eye Care Center
Indiana University
School of Optometry

Patient Information

Title_____ Gender M ☐ F ☐

Patient Name _____
Last First Middle

Patient Address _____
Street City State Zip

Patient Home Phone _____ Patient Work Phone_____

Patient Cell Phone _____ Patient e-mail _____

Patient Date of Birth _____ Student ID # (if applies) _____

Employer _____

Person Responsible for Payment ☐ **and/or** **Permanent Address** ☐

Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Work Phone_____

Cell Phone_____

Insurance Information **Patients must present insurance card prior to exam.**

Type of Insurance _____ Relationship to Subscriber _____

Subscriber's Name _____ DOB _____ Ins ID # _____

Please answer the following questions: **May we bill to your bursar account?** yes ☐ no ☐

Yes ☐ No ☐ I authorize I.U. School of Optometry Faculty or investigators to publish any photographs or pertinent information concerning any care as may be needed for professional medical journals, books, or seminars in the interest of medical education, knowledge, and research. I understand that I will not be mentioned by name nor will I be identifiable from my photographs.

Yes ☐ No ☐ If I qualify for an upcoming research investigation, please inform me so that I may consider participating.

Yes ☐ No ☐ I authorize Atwater Eye Care Center to provide treatment and to file for my insurance benefits. I understand that I am responsible for any portion that they do not pay.

In compliance with CLAS Standards we are required to ask the following questions:

What is your preferred language of communication? _____

What is your ethnic origin and or racial group? _____

Privacy Practices

I give my permission to the School of Optometry to release information about my medical and/or financial to the following person(s) or optometry practice(s) listed here.

Name _____ Phone _____

Name _____ Phone _____

My signature below confirms that I have been given a copy of the **"Notice of Privacy Practices"** of the School of Optometry. I have read and I understand that I am responsible for payment of any balance that insurance will not pay.

Patient or Guardian Signature:_____

File Number _____
Office Use Only

Atwater Eye Care Center

Indiana University School of Optometry
800 E. Atwater Ave. • Bloomington, IN 47405 • (812)855-8436

TIME _____ AM / PM

Date _____/_____/_____

Name _____ M / F Age _____ DOB _____ Race _____

Chief Complaint:

Secondary Complaint:
+ / - Diplopia
+ / - Headaches
+ / - Flashes
+ / - Floaters
+ / - Halos

POHx: Last Exam _____ By Whom _____ Last Dilation _____

Contact Lens Wear
☐ See other side

PMHx: Last Physical _____ By Whom _____
☐ Diabetes
☐ Reviewed intake form
☐ Change in medical condition

KMA/KEA:
☐ Reviewed intake form
☐ Change in allergies

Medications: (Including OTC)
☐ Reviewed intake form
☐ Change in medication

FHx:
☐ Reviewed intake form
☐ Change in history

FOHx
☐ Glaucoma
☐ Macular Degeneration
☐ Retinal Detachment
☐ Other Eye Disease

SHx: Occupation/Hobbies/CRT Use

☐ Appropriate and Oriented x3

Additional comments:

CONTACT LENS PROGRESS EXAMINATION

Name _____ Date ___/___/___ Purpose for Visit Dispense OD OS OU Follow up _____

Subjective

Lens Type_____
OD _____
OS _____
Base Curve Diameter
OD_____ OD_____
OS_____ OS_____

WT Today_____Usual_____Max_____
DW EW QFR MFR 2WD 1WD 1D
❑ Monovision Near Eye OD OS ADD ____
Care System
Enzyme Type_____ @ _____

Objective

Distance VA OD 20/ ____ OS 20/ ____ OU 20/____
Near VA OD 20/ ____ OS 20/ ____ OU 20/____

Retinoscopy OD _____
OS _____
Over Refraction OD _____
OS _____
Over-K's OD _____
(Δ K) OS _____

OD OS

T N L E Movement T N L E
T N L E Lag T N L E
T N L E Sag T N L E

C S I T N Centration C S I T N
0 1 2 3 4 Deposits 0 1 2 3 4
S On K ATR WTR NaFl S On K ATR WTR
LA IP Mixed RGP Fit LA IP Mixed
❑ Partial Blink ❑ Excessive Edge Standoff

Assessment

Intern
Yes No Acceptable Fit? Yes No

Consultant
Yes No Acceptable Fit? Yes No

❑ Agree with Intern

Plan

Intern Consultant

❑ Refit Lenses ❑
❑ Replace lenses ❑
❑ Patient Ed I/R Lens Care ❑
❑ Lid Hygiene ❑
❑ Use of Ocular Lubricants ❑

RTC
Intern _____

❑ Agree with Intern
Consultant _____ RTC

Additional Internal Notes

Atwater Eye Care Center

Indiana University School of Optometry
800 E. Atwater Ave. • Bloomington, IN 47405 • (812)855-8436

Name_____ Date ____/____/____

C/C_____ Patient PD _____ R_xPD _____

	Distance (∞)	Near (40 cm)
VA	OD 20/___ PH 20/___	OD 20/___
$\bar{c}$ R_x	OS 20/___ PH 20/___	OS 20/___
s R_x	OU 20/___	OU 20/___

Habitual R_x

OD _____

OS _____

Add _____ Inter _____ Prism _____

Preliminary Evaluation

Versions _____ Motility _____ ❑ Restriction(s)

Cover Test Distance_____ Near _____

Fields WNL ❑ OD OS ❑ Type_____

Amsler WNL ❑ OD OS ❑ _____

Pupils	Light	Dark		Light	Dark
OD	____mm/	____mm	OS	____mm/	____mm

PERRLA _____/_____ (Dir/Cons) + / – APD OD / OS Grade _____

External: Iris Color _____

Lids/Lashes _____ ❑ Ptosis OD / OS

Conjunctiva _____

Refraction

Keratometry OD _____ @ _____/_____ @ _____

OS _____ @ _____/_____ @ _____

Retinoscopy OD _____ 20/

OS _____ 20/

Monocular OD _____ 20/

Subjective OS _____ 20/

BVA OD _____ 20/

Balance OS _____ 20/

20/

Accommodation/Vergence Testing

NPC _____ NPA _____

Stereopsis _____ Method _____

Color Vision OD_____ OS_____ Method_____

NRA _____ PRA _____ BCC _____

Preferred reading distance _____ cm.

Tentative Add _____ 20/

20/

Range OD _____ to _____ cm.

OS _____ to _____ cm.

	Distance	Near
Phoria	Horiz _____	Horiz _____
Vergence	BI ____/____/____	BI ____/____/____
	BO ____/____/____	BO ____/____/____

Phoria	Vert _____ R / L hyper	Vert _____R / L hyper
Vergence	Sup ____/____R / L	Sup ____/____R / L
	Inf ____/____R / L	Inf ____/____R / L

Gradient (+ / – 1.00) _____

Maddox Rod _____

Associated Phoria Distance _____ Near _____ Method _____

Accom Facility _____ Method _____

Dynamic Retinoscopy _____ Method _____

Other Testing _____

R_x

OD _____ 20/

OS _____ 20/

Add _____ Inter _____ Prism _____ 20/ Near

Intern _____

Final R_x

OD _____ 20/

OS _____ 20/

Add _____ Inter _____ Prism _____ 20/ Near

Consultant _____

IOP (Method) _____ Time ___ ___ AM / PM OD _____mm Hg OS _____mm Hg Blood Pressure_____RA / LA Seated / Supine Time_____ AM / PM

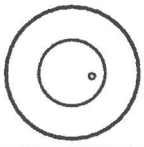
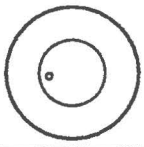
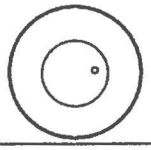
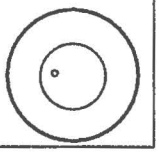
Dilate ? Y N Pharm Agents: Tropicamide 0.5 % 1.0 % Phenylephrine 2.5 % Cyclopentolate 1.0 % 2.0 % ❑ Rev-Eyes

Name _____ Date ____/____/____

Ocular Health: Anterior

OD	Intern	OS	OD	Consultant	OS
				WNL WNL	
	Lids/Lashes			☐ Lids/Lashes ☐	
	Conjunctiva			☐ Conjunctiva ☐	
	Sclera			☐ Sclera ☐	
	Angles			☐ Angles ☐	
	Cornea			Cornea	
	Epithelium			☐ Epithelium ☐	
	Stroma			☐ Stroma ☐	
	Endothelium			☐ Endothelium ☐	
	A/C			☐ Iris/Pupil ☐	
	Iris/Pupil			☐ A/C ☐	
	Lens/Media			☐ Lens/Media ☐	

Ocular Health: Posterior

OD	Intern	OS	OD	Consultant	OS
	Media			WNL WNL	
	Nerve head			☐ Media ☐	
	C/D ratio			Nerve Head	
	Shape/Type/Depth			C/D Ratio	
	Rim/Margins			☐ Posterior Pole ☐	
	VP			☐ Vessels ☐	
	Posterior Pole			☐ Macula ☐	
	A/V			☐ Periphery ☐	
	ALR				
	Crossings				
	Macula/FLR				
	Periphery			☐ See Back of Page 2	
					

Assessment	Intern	Consultant
		☐ Agree with Intern

Plan	Intern	Consultant
		☐ Agree with Intern

Intern_____ Consultant _____

University Eye Center

FERRIS STATE UNIVERSITY · MICHIGAN COLLEGE OF OPTOMETRY

Patient Health Information

Name	Social Security Number	Today's Date
Address, City, State, ZIP	Home Telephone Work Telephone	Birth Date

Thank you for taking your time to carefully complete the patient health information form. This information will be reviewed by the doctor during your examination. All information provided will be held in strict confidence.

PERSONAL EYE HISTORY

- Have you had your pupils dilated? Y N If yes, were there any problems? _____
- Do you wear glasses? Y N If yes, how old are your glasses? _____
- Does your occupation or any hobbies/recreational activities require the use of safety eyewear? Y N
- Date of last complete eye exam _____ Name of eye doctor _____
- Have you ever worn contact lenses? Y N Do you now wear contact lenses? Y N
  What type of contact lenses? Hard/RGP Soft Extended Bifocal
- Are you planning to get new glasses or contact lenses today? Y N Maybe
- Are you interested in learning about laser vision correction or non-surgical vision correction? Y N Maybe

Please note any family members with the following conditions.

EYE CONDITIONS	YES	NO	UNSURE	RELATIONSHIP
◆ Blindness				
◆ Glaucoma				
◆ Macular Degeneration				
◆ Other				

Name of Vision Insurance

_____

PERSONAL MEDICAL HISTORY

- List medications you are currently taking (prescription and over-the-counter). _____
- Do you have any allergies to medications? Y N If yes, please explain. _____
- List major illnesses, injuries, and surgeries you have had. _____
- Date of your last physical exam _____ Are you pregnant / nursing? Y N
- Name and office location of your medical doctor(s) _____

FAMILY MEDICAL HISTORY

Please note any family members with the following conditions.

MEDICAL CONDITIONS	YES	NO	UNSURE	RELATIONSHIP
◆ Arthritis				
◆ Cancer				
◆ Diabetes				
◆ Heart Disease				
◆ High Blood Pressure				
◆ Other				

Name of Medical Insurance*

_____

*Medical Insurance will only cover your visit if there is a medical reason such as loss of vision, headaches, eye redness, eye pain, eye itching, eye burning, glaucoma, cataracts, etc.

SOCIAL HISTORY

- What is your occupation? _____
- Do you use a computer at work or at home? Y N
- List your hobbies/recreational activities. _____
- Do you drive? Y N If yes, do you have visual difficulty when driving? Y N
- Do you use tobacco products? Y N If yes, what type/amount/how long? _____
- Do you drink alcohol? Y N If yes, how often? _____
- Do you use illegal drugs? Y N
- Have you ever been exposed or infected with the following: HIV? Y N TB? Y N