PATIENT: _____ **AGE:** _____ **DATE:** _____

CC: _____ **Dr. O'Daniel**

VA	OD	OS	OU
Hab.	20/	20/	20/
w/o	20/	20/	20/
Near	20/	20/	20/

Color Vision [ ] Yes [ ] No **Stereopsis** [ ]Yes [ ]No

Pupils ☐ **PERRL**
APD ☐ **No** ☐ Yes

V.F. Confrontations / **FDT**
☐ **Full OU** ☐ defect OD / OS / OU

- **Symptoms:** _____
- **Location:** OD OS OU _____
- **Quality:** Blur Pain Tear Dry Itch Red _____
- **Severity:** Mild Mod Severe - Pain ___/10
- **Duration:** _____ Day Week Month Year
- **Timing:** Acute Constant Intermittent _____
- **Context:** Far Near Computer _____
- **Modifiers:** Drops / Glasses help _____
- **Head/Face** ☐ **Normal**
- **Mood/Affect** (anxiety/agitation/depression) ☐ **Normal**
- **Oriented** (person/time/place) ☐ **Yes** ☐ No

HabRx	**OD**	20/	Add+
	OS	20/	bi / tri / pal
K's	OD /	@	S / D
	OS /	@	S / D
Auto	OD		
	OS		
#7	**OD**	**20/**	**Ph**
	OS	**20/**	**Ph**

C.T. Dist. Ortho Near NPC

Versions ☐ **Smooth & Full OU** ☐ restricted

Phorias	Lateral	Vertical
	Dist.	
	Near	
	NRA	VA'S 20/
Near	PRA	20/
	Ranges	

Lids/Lashes	☐ clear OU	Vitreous	☐ clear OU
Conj.	☐ clear OU	Macula	☐ clear OU
Corneas	☐ clear OU	Vessels	☐ clear OU
Lens	☐ clear OU	ONH	☐ clear OU
Iris	☐ clear OU	Periphery	☐ clear OU
A.C.	☐ clear OU		

Angle. OD: 0 1 2 3 4 **OS**: 0 1 2 3 4 **C/D OD**_____ **OS**_____

Tonometry **OD** _____ ☐ NCT ☐ **Icare** ☐ Goldman
OS _____ @ _____am / pm

Dilated OD OS **OU** Time: _____ am / pm
Procaine ☐ T 1/2% 1% ☐
PE 2.5% ☐ **Paremyd** ☐

Dermato___ **NS**___ **AC**___ **PCO**___
Pterygium___ Bleph_____
Arcus__
Ping__
Cells___
Conj Inj ___ NaFl **SPK**___ **TBUT**___

Dermato___ **NS**___ **AC**___ **PCO**___
Bleph_____ Pterygium__
Arcus__
Ping__
Cells___
Conj Inj ___ NaFl **SPK**___ **TBUT**___

Floaters___ PVD___
___**RPE Change**___
Dry **ARMD**___ Drusen___

Floaters___ PVD___
Dry **ARMD**___ Drusen___

☐ Direct
☐ 78D
☐ **90 D**
☐ SF
☐ 20D
☐ **Photo**

IMPRESSION
1)
2)
3)
☐ **Ocular Health Clear and Quiet OU**

PLAN RTO: _____ day week month - **1 year** default
1) Monitor Rx _____
2) Monitor Rx _____
3) Monitor Rx Refer _____
4) **Order** - **Photos OCT VF**_____ _____

NOTES:

Myopia **H52.1**__ Astig **H52.22**__ Hyper **H52.0**__ Pres **H52.4**
NS **H25.1**__ DES **H16.223** ARMD **H35.3131** DM2 **E11.9**

New	**Estab**	**New**	**Estab**			
[ ] S0620 $120	[ ] S0621 $90	[ ] 92004	[ ] 92014	[ ] 92015	[ ]_____	[ ]_____	[ ]_____

☐ **Contact lens fitting** – see CL fitting sheet

FINAL SPECTACLE RX: PD____/____

Add
OD_____
+ _____
OS _____

☐ +.25 PAL/Tri

Dr._____
[ ]O'Daniel [ ]Fuller [ ]McPhelan [ ]Felton

Mr.___ Mrs.___ Ms.___ Dr.___ **Date** ____/____/_____

Last Name _____ **First** _____ Patient ☐ New / ☐ Previous

Address _____ **City**_____ **Birth Date** ____/____/_____

State _____ **Zip** _____ **Email** _____ **Occupation**_____

Phone: **Home** _____ **Work** _____ **Cell** _____ Last Eye Exam mo____/yr_____

Vision Insurance _____ ID# _____ Medical Insurance _____ ID# _____

Primary Member's Name _____ Primary's Last 4 SSN _____ Primary's Birth Date ____/____/____

Referred by: ☐ Family ☐ Friend ☐ Co-worker ☐ Insurance ☐ Drove by ☐ Internet Site _____

Do you have any allergies to medications? ☐ no ☐ yes If yes, explain: _____

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

_____

_____

IF YOU ARE A **PREVIOUS PATIENT** AND THERE ARE NO CHANGES IN YOUR OCULAR/MEDICAL OR FAMILY HISTORY YOU MAY CHECK THE APPROPRIATE BOX AND SKIP THAT SECTION. ☐ No change in Ocular Medical History ☐ No change in Family History

PATIENT'S OCULAR/ MEDICAL HISTORY

Last Medical Exam ____/____/_____ Medical Dr's Name _____

List all major injuries, surgeries and/or hospitalizations you have had_____

_____

_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

Are you pregnant and/or nursing? ☐ no ☐ yes

Do you wear glasses? ☐ no ☐ yes If yes, how old is your present pair of glasses? _____

Do you wear contact lenses? ☐ no ☐ yes If yes, what is the brand and power? _____

Are they comfortable? ☐ no ☐ yes How often do you replace them? _____

Please check any conditions that you have or have had in the past:

☐ Loss of Vision	☐ Dryness	☐ Burning	☐ Chronic Infection of Eye/Lid
☐ Blurred Vision	☐ Mucous Discharge	☐ Foreign Body Sensation	☐ Styes or Chalazions
☐ Distorted Vision/Halos	☐ Redness	☐ Excess Tearing/Watering	☐ Flashes/Floaters in Vision
☐ Loss of Side Vision	☐ Sandy or Gritty Feeling	☐ Glare/Light Sensitivity	☐ Tired Eyes
☐ Double Vision	☐ Itching	☐ Eye Pain or Soreness	☐ Other_____

FAMILY HISTORY

Please check any conditions that apply to your immediate family members:

☐ Blindness	☐ Macular Degeneration	☐ Cancer	☐ Kidney Disease
☐ Cataract	☐ Retinal Detachment	☐ Diabetes	☐ Lupus
☐ Crossed Eyes	☐ Retinal Disease	☐ Heart Disease	☐ Thyroid Disease
☐ Glaucoma	☐ Arthritis	☐ High Blood Pressure	☐ Other_____

NOTICE OF PRIVACY

Acknowledgement of Receipt of Privacy Notice

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law designated to protect the privacy of your health information. We understand that the information about you and your health is personal and our doctors and staff are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your protected health information to any party. This office will only use and disclose necessary personal health information to permit the office to perform its administrative duties, provide eye care services, process vision benefit claims, or mail exam recalls. By signing below, I acknowledge that I have read/received the copy of the Notice of Privacy Practices for review.

Patient Signature _____