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PHILIPPIANS 4:13

EYE EXAM

Participant Name: _____

Appointment Date: _____

Reason for Visit: ☐ Eye Exam Other _____

I have provided a current list of medications and allergies. YES NO

_____

Provider Name (Print) Provider Signature Date

TO BE COMPLETED BY OPTOMETRIST:

1. Does patient wear glasses?	YES	NO	_____
2. Does patient wear contacts?	YES	NO	_____
3. Did the prescription change?	YES	NO	_____
4. Are new glasses/contacts needed?	YES	NO	_____
5. Signs of infection?	YES	NO	_____
6. Signs of Cataracts?	YES	NO	_____
7. Signs of Glaucoma?	YES	NO	_____
8. Signs of Macular Degeneration?	YES	NO	_____
9. Signs of Retinal Detachment?	YES	NO	_____
10. Are there other abnormalities?	YES	NO	_____
11. Is a referral needed?	YES	NO	_____

Explain diagnosis/treatment/recommendations/medications/follow up if needed:

_____

_____

_____

_____

Next exam is due: _____

I have reviewed the current list of medications and allergies. YES NO NA

Is it safe for the client to receive PRN over-the-counter medications? YES NO UNKNOWN

Comments: _____

_____

_____

Physician Name (Print) Physician Signature Date

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