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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