MEDICAL EYE SERVICES, INC.

Sample Patient Exam Form Description:

Sample form to be used as a reference by eye care providers to keep proper exam records of each patient.

Patient Exam Form

Date:	Chief Complaint (CC):
Name:	POH:
DOB:	PMH:
PCP:	FOHx:
Occupation:	FMH:
Lifestyle Needs	Meds:
Mood/Affect: ☐ OX3 ☐ NL	Allergies: NKDA ☐ Last Eye Exam:
Current Rx: OD	OS ADD

Current CTLRX DW EW 1 day 2 wks 1 mo

OD

OS

		SC	CC	Near
VA	OD	20/	20/	J SC/CC
	OS	20/	20/	J SC/CC

R Reflex Clear OU **O** R

M 20/_____ 20/_____

K OD OS **N** add _____ **J**___

CT Far ortho_____ EOM F & S ☐
Near ortho_____ HIRSCH: central ☐
PERRLA (-) APD _____
CF: Full OU ☐ NPA: _____cm NPC: TTN ☐___

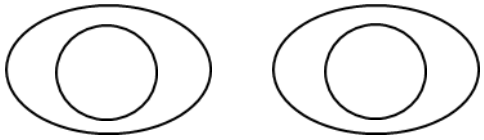
External
L/L ☐ Clear _____
Adnexa ☐ WNL _____
Dermato ☐_____ Blepharitis ☐_____

T A _____ @ __:___
TP
NCT _____
DIGITAL

SLE

OD

Other
Conj ☐ W/Q_____
Cornea ☐ Clear _____
A/C ☐ D/Q _____
Iris ☐ WNL _____
Angle Grade 1+ 2+ 3+ 4+ 0
Lens ☐ Clear _____



OD **OS**

OS

Other
_____ ☐ W/Q
_____ ☐ Clear
_____ ☐ D/Q
_____ ☐ WNL
1+ 2+ 3+ 4+ 0 Angle
_____ ☐ Clear

Patient refuses DFE at this time ☐

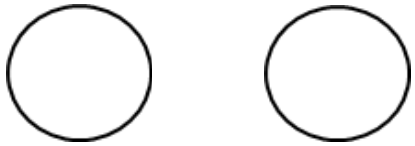
Dilate @ _N 2.5% M 1% C 1% N 10% M 0.5%

Warned of blurred vision, difficulty driving ☐

INTERNAL EXAM

OD

Other
Vit/Media ☐ NL _____
Macula ☐ NL _____
FR _____
ON ☐ NL _____
C/D _____
Retina/Vessels ☐ NL _____
A/V _____



OD **OS**

☐ Undilated

OS

Other
_____ ☐ NL
_____ ☐ NL
_____ FR
_____ ☐ NL
_____ C/D
_____ ☐ NL
_____ A/V

Contact Lens Fit Assessment	Additional Testing
Assessment / Dx	Plan / Tx *Please document needed referrals. Communication to PCP attached ☐
Final / Rx	☐ Patient's condition, treatment, alternatives communicated ☐ Education materials given _____ ☐ Consultation time _____ min. ☐ RT _____ days , mo, yr _____