SCOTT&WHITE

OUTPATIENT NOTES

NEURO OPHTHALMOLOGY CLINIC

DATE

OPHTH RETURN ( ) _____ _____
Doctor Date

PRIMARY CARE PHYSICIAN _____

AGE: _____

NEW PATIENT ( )
NEW CONSULT ( ) _____
Consulting physician

ORIGINAL REQUESTING PHYSICIAN _____

VISUAL ACUITY	Without Correction	With Correction	Pin Hole	Near
OD	_____	_____	_____	J_____
OS	_____	_____	_____	J_____

CURRENT GLASSES			
Single Vision ____	Bifocal ____	Trifocal ____	
Progressive ____	Readers ____	Contact Lens ____	
			PRISM
_____ + _____ x _____			[+]
_____ + _____ x _____			[+]

REFRACTION

Manifest Rx ____ _____ + _____ x _____ = _____ [+] = J _____

Auto Rx ____ _____ + _____ x _____ = _____ [+] = J _____

IOP (TA)
OD _____
OS _____ time _____

HRR Color Vision
OD _____ /10
OS _____ /10

VISUAL FIELDS
OD FTC _____ Abn _____
OS FTC _____ Abn _____

T N N T
OD OS

DILATION:
OD ___ Tropicamide 1% ___
OS ___ Phenylephrine 2.5% ___

Patient informed that dilation may affect ability to drive?
Yes ____ No ____

PUPILS
OD WNL _____ ABN _____
OS WNL _____ ABN _____

comment

CHIEF COMPLAINT: _____

PAST OCULAR HISTORY: NONE ( )

_____
_____
_____
_____
_____
_____
_____

PAST MEDICAL HISTORY: NONE ( )
HTN ( ) DM ( ) _____ years of DM

_____
_____
_____
_____
_____
_____

EYE MEDICATIONS: NONE ( )
☐ **Medications reconciled** _____

_____
_____
_____
_____

OTHER MEDICATIONS: NONE ( )
☐ **Medications reconciled** _____

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES: NKDA ( )

_____
_____

SCOTT&WHITE
OUTPATIENT NOTES

NEURO
OPHTHALMOLOGY CLINIC (continued)

FAMILY HISTORY: NONE ( )

_____

_____

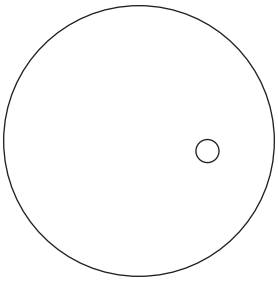
SOCIAL HISTORY:

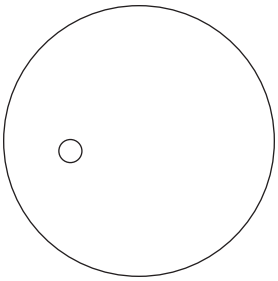
TOBACCO? yes ( ) no ( ) EtOH? yes ( ) no ( )

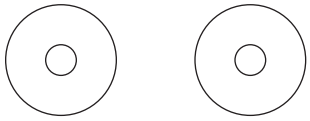
OCCUPATION: _____

REVIEW OF SYSTEMS:	**NO**	**YES**	**COMMENT**
Chronic fever, unexpected weight loss/gain, fatigue?	( )	( )	_____
Ear/nose/throat problems (e.g., hearing loss, sore throat)	( )	( )	_____
Heart problems (e.g., chest pain, irregular heart beat)	( )	( )	_____
Respiratory problems (e.g., shortness of breath, wheezing, cough)	( )	( )	_____
Gastrointestinal problems (e.g., heartburn, nausea, diarrhea)	( )	( )	_____
Urinary problems (e.g., pain or discomfort, blood in urine)	( )	( )	_____
Skin problems (e.g., rashes, ulcers)	( )	( )	_____
Musculoskeletal problems (e.g., muscle aches, joint pain)	( )	( )	_____
Neurologic problems (e.g., numbness, weakness, new headache)	( )	( )	_____
Psychiatric problems (e.g., depression, new anxiety)	( )	( )	_____
Hematologic/lymphatic problems (e.g., free bleeder, large nodes).	( )	( )	_____
MENTAL STATUS:			
Oriented to person, place and time	( )	( )	
Mood and affect appropriate	( )	( )	

NOTES:







FUNDUS **OD** C/D = 0._____ FUNDUS **OS** C/D = 0._____

_____
Physician Signature/Initials

☐ MEDICATION RECONCILED BY PHYSICIAN _____

MISC. TESTS	OD	OS
PAM		
BAT		
HERTEL BASE =		

Rx Given

OD _____ + _____ x _____ [+] PRISM

OS _____ + _____ x _____ [+]