

Office Use Only	
Date _____	Country: USA
Clinic _____	

## PATIENT VISION RECORD

### Personal

Last Name	First Name	MI	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Address		City	State	Zip
Email	Phone	Birth Date	Age	

### Assessment

Worn Eyeglasses Before? <input type="checkbox"/> Yes <input type="checkbox"/> No	Last Eye Exam (Years):	Current Medications:
<b>Medical History:</b> Self/Family Diabetes <input type="checkbox"/> / <input type="checkbox"/> Glaucoma <input type="checkbox"/> / <input type="checkbox"/> HTN <input type="checkbox"/> / <input type="checkbox"/> Cataracts <input type="checkbox"/> / <input type="checkbox"/> Cholesterol <input type="checkbox"/> / <input type="checkbox"/> Other _____	<b>Chief Complaint:</b> <input type="checkbox"/> Difficulty Seeing FAR <input type="checkbox"/> Difficulty Seeing NEAR <input type="checkbox"/> Headaches <input type="checkbox"/> Other _____	<b>Ethnicity:</b> <input type="checkbox"/> African-American <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Other _____

STATION 2

	WithOUT	WITH Rx	PinHole	AUTOREFRACTION
OD	20/	20/	20/	OD
OS	20/	20/	20/	OS
TONOMETER			CURRENT GLASSES	
OD	Time of Day AM or PM		OD	
OS			OS	
REFRACTION			ADD	VA's
OD				20/
OS				

STATION 3

Anterior Segment Evaluation Wholly unremarkable, except as noted:	Posterior Segment Evaluation Wholly unremarkable, except as noted:
OD	OD
OS	OS
Provider's Signature _____ Printed Name _____ Date _____	
Referral:    AMD            Cataracts            Diabetic Retinopathy            Glaucoma            Other _____	

STATION 4

OPTICAL					
PD	FRAME DESCRIPTION			Bifocal Height	Lab Account
	MODEL	SIZE	COLOR		EVF    VSP
OD					BVBH
OS					