



Dean S Reynolds, OD
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4025 Jackie Road SE: Rio Rancho, New Mexico 87124 New Existing

Today's Date: _____ Last Exam: _____ By: _____

Habitual RX: OD: _____ Other RX: OD: _____
 OS: _____ Contact Lenses: OS: _____
 Add: _____ Add: _____

Chief Complaint: _____

History of Present Illness (HPI) Brief (1-3) Extended (4-8) Vision Exam Only

Location: _____ Timing: _____
 Quality: _____ Context: _____
 Severity: _____ Modifiers: _____
 Duration: _____ Associated Signs: _____

Past, Family, Social History (PFSH) Pertinent (1) Comp (2 for established) (3 for new) See History Form

• **Patient Past History** Cataract Surgery: N/Y _____ OD _____ OS _____
 Ocular: _____ Medical: _____ Medications: _____
 • **Family History**
 Ocular: _____ Medical: _____
 • **Social History**
 Occupation: _____ Employer: _____
 Use Alcohol? N/Y Amount? _____ Tobacco N/Y Amount? _____

Review of Systems (ROS) PP (1) Extended (2-9) Completed (10-12)

From ____/____/____ By Dr. _____ No Changes Changes _____

Acuity

Eye	VA w/ Old RX		Glasses/Contacts		Unaided VA		BP/Pulse
	Far	Near	Far	Near	Far	Near	
OD	20/	20/	20/	20/	20/	20/	
OS	20/	20/	20/	20/	20/	20/	
OU	20/	20/	20/	20/	20/	20/	

Ocular Motility:

Cover Test Far _____ Δ Near _____ Δ NPC _____
 Pursuits: S & A Rough: Mild Mod Severe
 Ishihara Color: P/F _____ Randot Stereo: _____/9 or Sec Arc

Refraction

Ret OD _____ 20/ MRx OD _____ 20/
 OS _____ 20/ OS _____ 20/
 Sub OD _____ 20/ Add _____ 20/
 OS _____ 20/

Phorias: Far Vert _____ Δ Hor _____ Δ BCC: _____ 20/ PRA _____ NRA _____
 Near Vert _____ Δ Hor _____ Δ Acc Amp: _____ Acc Facility _____

•K's OD _____ / _____ @ _____
 OS _____ / _____ @ _____


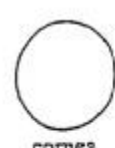
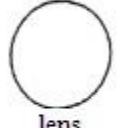



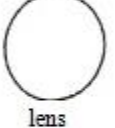

CL: _____

•Appropriately Oriented to Person, Place, Time: Yes/No
 •Mood appears appropriate for circumstances: Yes/No
 •Pupils: PERRLA Size => APD NO YES OD/OS
 •Gross Fields: Auto: Full/Defect (See Chart) CF: Full/ Amsler: Normal/Defect (See Chart)
 •Tonometry: Goldman Applanation Proview Patient Refuses
 OD _____ mmHg OS _____ mmHg Time _____ AM/PM Pre/Post DFE
 OD _____ mmHg OS _____ mmHg Time _____ AM/PM Pre/Post DFE

Dilation: Patient advised of risks and benefits of dilation. Patient Accepts Declines Optomap iWellness

DPA: M .5% 1% C 1% 2% N 2.5% Alcaine .5% Fluress iggt OD/OS@ _____

Diagnostic Lenses Used: 90D 78D 20D Direct **Corrected VA after dilation:** OD 20/ OS 20/

   	<p>OD</p> <p>CI <input type="checkbox"/></p> <p>W/Q <input type="checkbox"/></p> <p>CI <input type="checkbox"/></p> <p>D/Q <input type="checkbox"/> 1: _____</p> <p>F/I <input type="checkbox"/> X</p> <p>CI <input type="checkbox"/></p> <p>Pink <input type="checkbox"/></p> <p>Healthy <input type="checkbox"/></p> <p>F/I <input type="checkbox"/></p> <p>Intact 360° <input type="checkbox"/></p> <p>Floaters/PVD</p>	<p style="text-align: center;">Slit Lamp Exam</p> <p style="text-align: center;">Adnexae (<i>Lid, Lashes, Lacrimal Orbit</i>)</p> <p style="text-align: center;">Conjunctiva</p> <p style="text-align: center;">Cornea</p> <p style="text-align: center;">Anterior Chamber 1: _____</p> <p style="text-align: center;">Iris X</p> <p style="text-align: center;">Lens</p> <p style="text-align: center;">Optic Disc</p> <p style="text-align: center;">C/D</p> <p style="text-align: center;">Depth</p> <p style="text-align: center;">Appearance</p> <p style="text-align: center;">Nerve Fiber layer</p> <p style="text-align: center;">Fundus</p> <p style="text-align: center;">A/V</p> <p style="text-align: center;">Macula</p> <p style="text-align: center;">Peripheral Retina</p> <p style="text-align: center;">Vitreous</p>	<p>OS</p> <p>CI <input type="checkbox"/></p> <p>W/Q <input type="checkbox"/></p> <p>CI <input type="checkbox"/></p> <p>D/Q <input type="checkbox"/></p> <p>F/I <input type="checkbox"/></p> <p>CI <input type="checkbox"/></p> <p>Pink <input type="checkbox"/></p> <p>Healthy <input type="checkbox"/></p> <p>F/I <input type="checkbox"/></p> <p>Intact 360° <input type="checkbox"/></p> <p>Floaters/PVD</p>	   
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Diagnosis	Treatment/Plan
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
	RTC F/U

Dr. _____ Date: _____

Elements of Eye Examination • Problem Focus (1-5) Exp. Focus (6-8) Detailed (9-11) Comprehensive (12+ Neuro)

MEDICAL DECISION MAKING (2 OF 3)							
# of Diags or options	Amt/Complexity of data Add total			Risk of complications		Result	
<input type="checkbox"/> Ext (New prb-and/ w/up) 4	<input type="checkbox"/> Review old records 2	<input type="checkbox"/> Ext 4	<input type="checkbox"/> High (Acute or chronic with severe progression)			<input type="checkbox"/> High	
<input type="checkbox"/> Multi (New prob-no add) 3	<input type="checkbox"/> Review ord lab test 1	<input type="checkbox"/> Mod 3	<input type="checkbox"/> Mod (1 progressing chronic or 2 chronic stable)			<input type="checkbox"/> Mod	
<input type="checkbox"/> Ltd (Est Prob-worse)	<input type="checkbox"/> Rv/w/ord/dis spec test	<input type="checkbox"/> Ltd 2	<input type="checkbox"/> Low (2 or more self-limiting or minor problems)			<input type="checkbox"/> Low	
<input type="checkbox"/> Min (Minor/est prb stabl)	<input type="checkbox"/> Get old records	<input type="checkbox"/> Min 0-1	<input type="checkbox"/> Min (1 limiting or minor problem)			<input type="checkbox"/> St Fw	
EVALUATION/MANAGEMENT LEVEL SUMMARY							
New Patient (3 of 3)				Established Patient (2 of 3)			
HISTORY	EXAM	DECISN	RESULT	HISTORY	EXAM	DECISN	RESULT
<input type="checkbox"/> Complete	<input type="checkbox"/> Comp 12+	<input type="checkbox"/> High	<input type="checkbox"/> 99205	<input type="checkbox"/> Comp	<input type="checkbox"/> Comp 12+	<input type="checkbox"/> High	<input type="checkbox"/> 99215
<input type="checkbox"/> Complete	<input type="checkbox"/> Comp 12+	<input type="checkbox"/> Mod	<input type="checkbox"/> 99204	<input type="checkbox"/> Detail	<input type="checkbox"/> Detail 9-11	<input type="checkbox"/> Mod	<input type="checkbox"/> 99214
<input type="checkbox"/> Detailed	<input type="checkbox"/> Detail 9-11	<input type="checkbox"/> Low	<input type="checkbox"/> 99203	<input type="checkbox"/> Ex Foc	<input type="checkbox"/> Expand 6-8	<input type="checkbox"/> Low	<input type="checkbox"/> 99213
<input type="checkbox"/> Expanded	<input type="checkbox"/> Expand 6-8	<input type="checkbox"/> St Fw	<input type="checkbox"/> 99202	<input type="checkbox"/> Pr Foc	<input type="checkbox"/> Pr Foc 1-5	<input type="checkbox"/> St Fw	<input type="checkbox"/> 99212
<input type="checkbox"/> Problem	<input type="checkbox"/> Pr Foc 1-5	<input type="checkbox"/> St Fw	<input type="checkbox"/> 99201	<input type="checkbox"/> Supervision			<input type="checkbox"/> 99211