EXAMINATION FORM

Name	Age	Date	Time	☐ Appt ☐ Walk-in	Tech

Chief Complaint / History

Current Glasses / Contact Lens

	Sph	Cyl	Axis	Prism	Add
OD					
OS					

☐ Glass ☐ Plastic ☐ Poly ☐ Bif ☐ Trif ☐ Prog

Secondary Glasses

	Sph	Cyl	Axis	Prism	Add
OD					
OS					

☐ Glass ☐ Plastic ☐ Poly ☐ Bif ☐ Trif ☐ Prog

UNAIDED
OD 20/
OS 20/
OU 20/

AIDED ☐ Check if VA with CL
OD 20/
OS 20/
OU 20/

NCT Avg.
OD ____ ____ ____
OS ____ ____ ____
Time:
Blood Pressure:

Depth / Stereo ☐ w/RX ☐ w/o RX
/6

Color Ishihara
/13
(# correct / # tested)

Amsler Grid ☐ Y ☐ N

If yes,	Norm	See Sheet
OD	☐	☐
OS	☐	☐

Retinal Photos ☐ NA

	Norm	Other
OD	☐	☐
OS	☐	☐

Confrontations

	Normal	Restricted
OD	☐	☐
OS	☐	☐

Muscle Balance FAR FAR
☐ Cover Test H NEAR V NEAR
☐ Phoropter

External: face, lids, conj, sclera ☐ Normal
Pupils: ☐ Perria Swinging Light: ☐ Normal
Extraocular Motions: ☐ Full ☐ Smooth Pd________
NPC:____________
☐ Retinoscopy OD
☐ (AR Reading) OS

Refraction

			ADD
OD		20/	20/
OS		20	20

	Keratometry	Distortion
OD		
OS		

Slit Lamp

	OD	OS	normal		OD	OS	normal
Lids	☐	☐		A/C	☐	☐	
Conj	☐	☐		Iris	☐	☐	
Cornea	☐	☐		Tears	☐	☐	
Lens	☐	☐		Angles ____________			

NOTES / AUXILIARY TESTING

Internal

	OD	OS	normal
Disc Mar	☐	☐	
Disc Color	☐	☐	
Mac/Foyea	☐	☐	
Vessels	☐	☐	
Post Pole	☐	☐	
Periphery	☐	☐	
A/V Ratio ________			

Disc	________	________
CD	________	________
CUP	________	________
DEPTH	________	________

DFE ☐ Yes ☐ No
DFA Used: ____________

IMPRESSIONS / Diagnosis

OU	REFRACTIVE	OD	OS
☐	No refractive error	☐	☐
☐	Myopia	☐	☐
☐	Astigmatism	☐	☐
☐	Presbyopia	☐	☐
☐	Anisometropia	☐	☐
☐	Hyperopia	☐	☐
☐	Pseudophakia (IOL)	☐	☐
☐	Amblyopia	☐	☐

OTHER ____________

BINOCULARITY
☐ No apparent problem
☐ Other:

OCULAR HEALTH
☐ No apparent pathology
☐ OD ☐ OS ☐ OU
☐ Other

Patient Education
☐ Adaptation to Rx
☐ Sg/Sx Retinal Detach
☐ Glaucoma Suspect
☐ Loss of vision / diabetes
☐ Hypertensive - see M.D.
☐ Cataracts
☐ Refractive Surgery

RECOMMENDATIONS:
☐ No Rx Needed
☐ Rx Change Optional
☐ New Rx Necessary
Rx To Be Worn: ☐ Full Time ☐ PRN

Final Rx: ☐ see above
OD
OS

Return Visit: ☐ 6 mon ☐ 1 yr ☐ 2 yr
Doctor: ____________
Tech: ____________

ALL COMPLAINTS, PATHOLOGY, AND SUSPICIOUS FINDINGS MUST BE EXPLAINED.

The Different Types of EXAMS...

MEDICAL EXAM: This exam is to evaluate and diagnose overall eye health where there are underlying systemic, medicinal, or vision issues to include red eyes, dry eye syndrome, allergic disorders, diabetic retinopathy, glaucoma, etc. If any type of prescription other than for vision correction is provided, the exam will be considered a medical exam.

ROUTINE VISION: A basic vision exam to provide an overall eye health evaluation and refraction. ***NO other vision problems exist.***

CONTACT LENSES FITTING & EVALUATION: An additional exam and fee for a contact lenses fitting and evaluation to include a trial pair of contact lenses and up to 2 follow-up visits to confirm the proper fit and comfort of contact lenses.

DILATION OF THE EYES: If the doctor feels it is necessary, the doctor will dilate your eyes. Dilation is a procedure where drops are instilled in the eyes to enlarge your pupils. This provides the doctor with a more thorough evaluation of the structures inside your eyes, for the detection of eye diseases such as Glaucoma, Cataracts, Tumors, Retinal Detachment, Diabetes, Hypertension, etc. Dilation may temporarily blur your vision and make you more sensitive to light (disposable sun shades will be provided). This process is included in the exam price and there is no extra charge if performed the same day. If rescheduled for another day, a $20.00 re-scheduling fee may apply.

Is it okay to dilate your eyes? YES RESCHEDULE DECLINE

DISCLAIMER: During your eye exam it is possible the doctor may desire to perform a pupillary dilation. Should you elect to receive such treatment, you acknowledge the fact Paula Emerson, O.D other contracted Optometrists, and Ingram Eye Care. STRONGLY RECOMMEND YOU DO NOT DRIVE A VEHICLE OR OPERATE ANY MACHINERY FOR A PERIOD OF AT LEAST TWO (2) HOURS thereafter. Dilation affects individuals in different ways, and in some patients can continue to adversely alter vision beyond such period of time. As a condition of performing a pupillary dilation, you agree to INDEMNIFY and DEFEND Paula Emerson O.D,. or other contracted Optometrists, Ingram Eye Care and all its agents and employees from any and all claim(s) and/or lawsuit(s) from third parties allegedly attributable to this procedure. Further, also as a condition of the dilation, you agree to RELEASE, ACQUIT, and FOREVER DISCHARGE Paula Emerson, O.D.,other contracted Optometrists, Ingram Eye Care., and all its agents and employees from any and all liability to third parties alleged to be attributed to this procedure.

Acknowledged and Agreed: ____SELF/ PARENT/ GUARDIAN