

Name: _____ DOB: _____ Age: _____ Date: _____ M/F

CC: Poor Vision / Pain / F&F / Red Eye / Lesion / POV _____

VA OD 20/____ sc/gl/cl OS 20/____ sc/gl/cl	OD 20/____ PH/AR OS 20/____ PH/AR	Pupils NL/ABNL	Dilation____ OD/OS	Allergies
IOP OD ____ ap/tp/ic OS ____ ap/tp/ic	LI OD 20/____ OS 20/____	CVF NL/ABNL	EOM NL/ABNL	

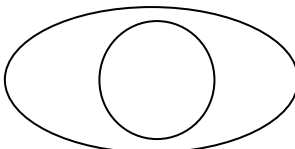
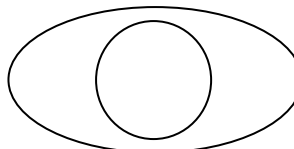
HPI Location Quality Severity Duration Timing Context Modifying Factors Associated Signs & Symptoms	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:70%;">Eye Medications</td> <td style="width:15%;">OD</td> <td style="width:15%;">OS</td> </tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> </table> Systemic Medications: 	Eye Medications	OD	OS	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Eye Medications	OD	OS																							
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	<u>OD</u>	<u>OS</u>
Vision	+ - no Δ	+ - no Δ
Floaters	+ - no Δ	+ - no Δ
Flashes	+ - no Δ	+ - no Δ
Glare	+ - no Δ	+ - no Δ
Distortion	+ - no Δ	+ - no Δ
Pain	+ - no Δ	+ - no Δ
Redness	+ - no Δ	+ - no Δ

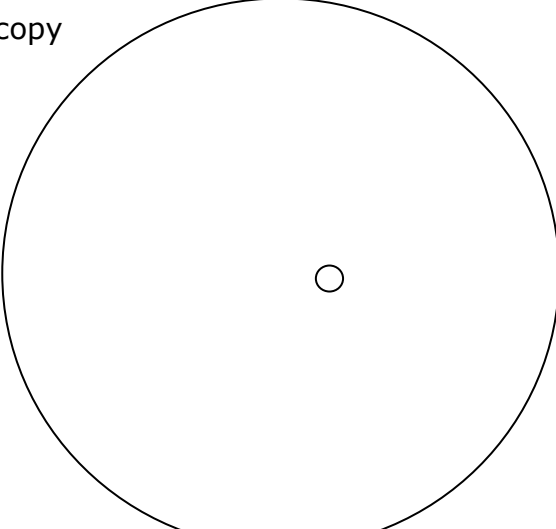
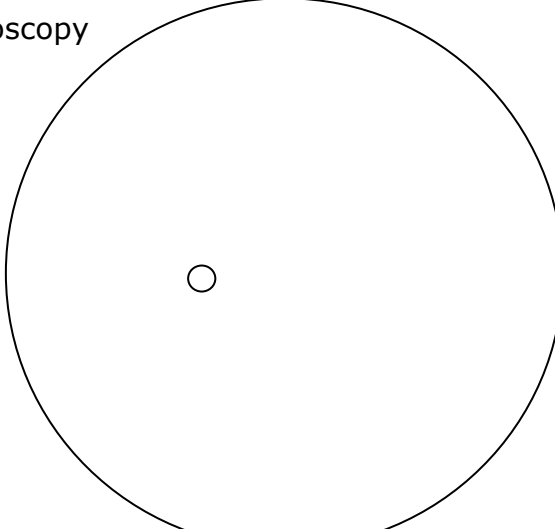
History & Flow Sheet: New / Updated

POH: <u>OD</u> ARMD Cataract CE/IOL YAG PK Ref Sx Glaucoma DR CRVO BRVO BRAO RD Laser	<u>OS</u> ARMD Cataract CE/IOL YAG PK Ref Sx Glaucoma DR CRVO BRVO BRAO RD Laser	PMH: DM HTN CAD CHF CVA Pulmonary GI Arthritis Cancer GU Thyroid	ROS: Wt Loss F/C ENT CV Resp GI GU MsSk Skin Neuro Endoc Heme Allerg Psych	FOH: Glaucoma ARMD RD/RT RP	SH: Occ _____ Tobacco EtOH Drug Abuse
				GMO: Mood: 😊 😐 😞 Orientation: A & O x 3	

Name: _____ DOB: _____

<p>EXT NL/ABNL L/L NL/ABNL Conj NL/ABNL K NL/ABNL AC NL/ABNL Iris NL/ABNL Lens NL/ABNL</p>  <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 0 auto;"> ___NS / ___ / PSC ___ / ACC Phakic / PC IOL / ACIOL / Aphakic PCO / YAG </div>	<p>EXT NL/ABNL L/L NL/ABNL Conj NL/ABNL K NL/ABNL AC NL/ABNL Iris NL/ABNL Lens NL/ABNL</p>  <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 0 auto;"> ___NS / ___ / PSC ___ / ACC Phakic / PC IOL / ACIOL / Aphakic PCO / YAG </div>
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<p>C/D 0. _____ AVit NL/ABNL ON NL/ABNL M NL/ABNL Edema/Heme/Exudate Mild/Mod/Severe GranRPE/Drusen/PED BV NL/ABNL Vit NL/PVD/ABNL P NL/ABNL/Flat 360/Dx 360</p>	<p>C/D 0. _____ AVit NL/ABNL ON NL/ABNL M NL/ABNL Edema/Heme/Exudate Mild/Mod/Severe GranRPE/Drusen/PED BV NL/ABNL Vit NL/PVD/ABNL P NL/ABNL/Flat 360/Dx 360</p>
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<p>Ophthalmoscopy</p> <div style="border: 1px solid black; border-radius: 50%; width: 100%; height: 100%; display: flex; align-items: center; justify-content: center;"> <div style="margin-right: 10px;">Interpretation:</div>  </div> <p style="text-align: right; font-size: small;">92225/92226/NC</p>	<p>Ophthalmoscopy</p> <div style="border: 1px solid black; border-radius: 50%; width: 100%; height: 100%; display: flex; align-items: center; justify-content: center;"> <div style="margin-right: 10px;">Interpretation:</div>  </div> <p style="text-align: right; font-size: small;">92225//92226NC</p>
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<p>OCT: Macula <input type="checkbox"/> Optic Nerve <input type="checkbox"/> Findings: IRE/SRF/VMT/Decr RNFL/ _____ Comp: Improved/Stable/Worse Utility: WetARMD/DME/MP/CME/CNVM/MH/Glaucoma/ _____ diagnosis/management/screening</p> <p style="text-align: right; font-size: small;">92133/92134/NC</p>	<p>OCT: Macula <input type="checkbox"/> Optic Nerve <input type="checkbox"/> Findings: IRE/SRF/VMT/Decr RNFL/ _____ Comp: Improved/Stable/Worse Utility: WetARMD/DME/MP/CME/CNVM/MH/Glaucoma/ _____ diagnosis/management/screening</p> <p style="text-align: right; font-size: small;">92133/92134/NC</p>
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<p>Impression:</p>	<p>Plan:</p>
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<p>Education: Pamphlet: _____ Surgery R/B/A – Informed Consent Amsler Grid w/ Instructions RD/RT Symptoms reviewed Vitamins/AREDS</p>	<p>Patient to Report: Decreased Vision Increased Pain Increased Redness F/F/S/C/V</p>	<p>Next Visit: _____ Dilate OD/OS OCT OD/OS IOP Check only Procedure _____</p>	<table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; font-size: small;">New</th> <th style="text-align: left; font-size: small;">Est</th> <th style="text-align: left; font-size: small;">Mod</th> </tr> </thead> <tbody> <tr> <td>99202</td> <td>99212</td> <td>-25</td> </tr> <tr> <td>92002_{oph}</td> <td>92012</td> <td>-57</td> </tr> <tr> <td>99203</td> <td>99213</td> <td>-79</td> </tr> <tr> <td>92004_{oph}</td> <td>92014</td> <td></td> </tr> <tr> <td>99204</td> <td>99214</td> <td>POV</td> </tr> <tr> <td>99205</td> <td>99215</td> <td>99204</td> </tr> </tbody> </table>	New	Est	Mod	99202	99212	-25	92002 _{oph}	92012	-57	99203	99213	-79	92004 _{oph}	92014		99204	99214	POV	99205	99215	99204
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99205	99215	99204																						

I personally examined this patient and I agree with the above documentation

Tech: _____ Scribe: _____ Physician: _____, M.D. Date: _____