PATIENT:

DATE	O.D.		
DV R 20/	NV R 20/		
L 20/	L 20/		
OU 20/	OU 20/		
UNAIDED SRX CL'S			

EYE CHECK

When did symptoms start?
Pain?_____ 1-10 _____
Itchy?_____ Red?_____
Matter or Discharge? _____
Recent injury or exposure to chemicals or irritants?_____
_____
Flashes of light or spots?_____

RX CHECK

Problem?
NV_____
DV_____
Describe concerns
_____
_____
_____
_____

OBJECTIVE

ASSESSMENT & PLAN

DIAGNOSIS	PROC. CODE	NEXT VISIT	OD
		☐ 1 WK ☐ _____ ☐ 1 YR	

DATE	O.D.		
DV R 20/	NV R 20/		
L 20/	L 20/		
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OBJECTIVE

ASSESSMENT & PLAN

DIAGNOSIS	PROC. CODE	NEXT VISIT	OD
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