VSP PATIENT EXAM FORM

Name: Date:	Occupation: Employer:
Address:	Spouse/Parents:
City/State: DOB:	Avocations:
Home: ( )	Special vision needs:
Work: ( )	

OCULAR HISTORY

Chief Complaint:

HPI: Location: Quality: Severity: Duration: Timing: Context: Moderating Factors: Associated S/S:

LEE:

LRx:

Unresolved problems from previous visit(s):

Patient's Ocular Symptoms

DVA:

NVA:

Strain/Dbl.:

Pain/Red:

Discharge:

Flsh/Flt:

H/A:

Past Ocular Hx:

General Health:

Last Physical Exam:
Review of Systems: _______________
Doctor's Initials

Past Family Medical History: _______________
Doctor's Initials

Past Family Ocular History: _______________
Doctor's Initials

Orientation/mood/affect:

Present Rx	From	Type			
Rx	Sphere	Cylinder	Axis	Prism	Base
O.D.					
O.S.					
Add					

VA w/Rx		Unaided		Pin Hole	
Dist	Near	Dist	Near		
OD 20/	/	20/	/		
OS 20/	/	20/	/	OD:	20/
OU 20/	/	20/	/	OS:	20/

Auto-Refr.	OD		Auto-K OD		Color Vision
PD:	OS		OS		
Cover Test	Dist EP XP	NPA D.	Pupils APD	Versions/EOM	
	Near EP XP	NPC cm TTN	Stereopsis	Blood Pressure /	
Cnfrt Visual Fields	OD	OS	Supplemental tests:		

Name:
Date:

Keratometry	OD OS	
Retinoscopy	OD OS	
	OD OS	
Subj. Refraction	OD 20 / OS 20 /	
Phoria (Dist)	Lateral	Vertical
Phoria (Near)		
PRA (-)		
NRA (+)		
SLE	OD	OS
L/L:		
Conj:		
Sclera:		
Tears:		
Cornea:		
Iris		
Ant.c.:		

Tonometry OD mm Hg OS mm Hg Time AM PM

DPAs (1) AM PM gtt(s)

(2) AM PM gtt(s)

BIO DIRECT VOLK HRUBY SCLERAL DEP.

INTERNAL	OD	OS
Lens: Media:		
Disc:		
Vessels:		
Retina:	through dilated pupils	
Macula:		

Assessment/Diagnosis

Treatment Plan

Signature ___________________________

RTC

_______day _______wk. _______ mo. ______ yr.

DIAGNOSTIC CONTACT LENS FITTING

Additional Case Hx:

Current CL specifications:
SLE w/ CL:

Overrefraction:

VA w/ CL:
VA w/out CL:

S/O response:

Diagnosis/Tx plan:

VDT EXAMINATION

Ocular work Hx:

VDT Rx:

NPC:

Phoria @ VDT work distance:

PRA @ VDT work distance:
NRA @ VDT work distance:

VDT Questionnaire completed: Y/N
Dx/Tx plan:

Notes:

Explained risks/benefits of dilation: Yes_____ No _____

Consultant/Lab Report:

Pt. Education/Instructions:
Follow-up Care/Visits:

Date / / For Constant Wear ☐ Distance ☐ Near ☐

Rx	Sphere	Cyl	Axis	Prism	Base
O.D.					
O.S.					
Add		Width	Seg Hgt.	Dist. PD	Near PD
O.D.					
O.S.					

Type	Tint
Frame	Coating

Eyesize	DBL	Color
LAB		Temples

Date / /

Rx	Sphere	Cyl	Axis	Prism	Base
O.D.					
O.S.					
Add		Width	Seg Hgt.	Dist. PD	Near PD
O.D.					
O.S.					

Type	Tint
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