GRACE EYECARE

1615 Cortelyou Rd
Brooklyn, NY 11226

Name _____ **Sex (M/F) Date** _____
Last **First** **Initial**
Mailing Address _____ **Zip Code** _____
Home Phone _____ **Work** _____ **Cellular** _____
Date of Birth _____/_____/_____ **Occupation** _____ **Sports/hobbies** _____
Last Medical Exam _____ **Last Eye Exam** _____ **Age of Present Glasses** _____
Reason for Visit _____

STOP - DO NOT FILL BELOW THIS LINE - DOCTOR'S USE ONLY

Eye Health - check all that apply:

___Blurred vision	___Eye tear, burn, itch	___Headaches	___Squinting	___Double Vision
___Eye Fatigue	___Bothered by lights	___Floaters	___Past injury to eye	___Computer use
___Glaucoma	___Detached Retina	___Cataracts	___No vision in eye	___Eye Surgery

General Health - check all that apply:

___Diabetes	___High blood pressure	___Thyroid	___Heart Problems	___Sinuses
___Allergies	___Medication (specify)	___Other (specify)		

Chief Complaint _____
History _____

Entering VA's (DV) **OD 20/** **PI** _____ **Old RX R** _____ **L** _____
(Aided/Unaided) **OS 20/** _____ **Add** ____ **RX age** _____ **Type** _____
OU 20/
CT **Dist** _____ **PERRLA (-)mg** **Color Vision OD** _____ **OS** _____
(Aided/Unaided) **Near** _____ **EOMS** _____ **Test Used** _____
Steropsis _____

K's OD _____ **Mires** _____
OS _____ **Mires** _____
Objective OD _____
OS _____
Subjective OD _____ _____
OS _____ _____ **OU** _____
Add _____
Final OD _____
OS _____
Add _____

External			Internal		
OD	**Lid/Adnexia**	**OS**	**OD**	**C/D**	**OS**
	Cornea/Selera			**A/V**	
	A/C/Angle			**Macula**	
	Iris			**Fovea**	
	Lens			**Periphery**	

Tonometer **OD**
Goldman/NCT **OS**
Time _____

Diagnosis & Recommendations _____