Annual Eye Health History – 8/24/22

- **Reason for Visit:** Annual Eye Health Exam
- **CC:** What brings you in today? Blurry vision/glare/dry eyes, etc. or yearly dilated exam if no new complaints
    - Both eyes?
    - Is one eye worse?
- **Duration of Problem:** How long has this been a problem?
- **Severity:**
    - How severe are your symptoms?
    - Are your symptoms stable, getting better, or getting worse?
- **Modifying Factors:**
    - Are your symptoms worse with any specific activity or during a certain time of day?
    - Have you found anything that has been helpful in relieving your symptoms?
- **Associated Symptoms:**
    - Do your eyes ever feel dry or uncomfortable?
    - Does your vision ever fluctuate throughout the day?
    - Are you experiencing any other problems with your eyes?
- **Pertinent Negatives: Record if applicable**
    - No change in vision
    - No discomfort

Cataract Evaluation History – 3/24/25

- **Reason for Visit:** Cataract Evaluation
- **CC:** What brings you in today? Blurry vision/decreased vision/glare, Dr. X said I had cataracts, etc.
    - Both eyes?
    - Is one eye worse?
- **Duration of Problem:** How long has this bothered you?
- **Severity:**
    - How severe are your symptoms?
    - Are your symptoms stable or getting worse?
- **Modifying Factors:**
    - Is your vision worse with any specific activity or during a certain time of day?
    - Have you found anything that has been helpful in relieving your symptoms?
- **Associated Symptoms:**
    - Do your eyes ever feel dry or uncomfortable?
    - Are you experiencing any other problems with your eyes?
- **Activity Affected:** Does your vision interfere with your everyday life? In what way? (reference ADL sheet)
- **CE:**
    - Have you ever had any eye surgery?
    - Have you ever had an eye injury/trauma?
    - History of eye irritation/dry eye or fluctuating vision?
    - Do you wear your glasses full time/part time/reading only/distance only?
    - Do you take your glasses off to read?
    - Do you have prism in your glasses?
    - Any history of contact lens use? Monovision? Multifocal? Last worn?
        - OD near
        - OS near
    - Would you like to be glasses free at distance/near or glasses free at all distances?
        - Ok wearing glasses/CL full-time post op
        - Would like IOL that is covered by insurance

Cataract Post-Op History – 5/6/2025

IPO

- Reason for Visit: Post Op: 1 Day post op
  - Which eye had surgery?
  - How is your vision in that eye?
    - This is also where you notate complaints like:
      - "Patient notices flutters/arcs of light"
      - "Patient notices temporal shadow"
  - Are you using your surgery drops?
    - What drops are you on? How are you using them?
      - "using drops as prescribed"
      - "last dose of drops *"

(SD)1 Week Refract/Discuss

- Reason for Visit: Post Op: 1 week post op
  - Which eye already had surgery?
  - Any complaints with eye that has had surgery already?
  - What drops are you using? Confirm surgery drops and dosage.
    - "using drops as prescribed"
    - "last dose of drops *"
  - Are you ready to proceed with your other eye? (Which eye?)
    - "Complains of poor vision in fellow eye affecting ADLs including*"
      - List out specific vision complaints i.e. trouble reading road signs, nighttime driving, watching TV etc.

Dry Eye Evaluation History – 8/24/22

- **Reason for Visit:** Consultation if referred, New Patient if self-referred, Follow Up if already seen by today's provider
- **CC:** What brings you in today? What symptom seems to be bothering you the most? Dry eyes/foreign body sensation/decreased vision/fluctuating vision/itching/pain/tearing etc.
    - Both eyes?
    - Is one eye worse than the other?
- **Duration of Problem:** How long has this bothered you?
- **Severity:**
    - How severe are your symptoms?
    - Are your symptoms stable, getting better, or getting worse?
    - Are your symptoms constant or do they come and go?
- **Modifying Factors:**
    - Are your symptoms worse with any specific activity or during a certain time of day?
    - Have you found anything that has been helpful in relieving your symptoms?
- **Associated Symptoms:**
    - What other symptoms are bothering you?
    - Blurry or fluctuating vision?
- **DED:**
    - How often are you using artificial tears?
    - What treatments have you tried in the past?
    - How many hours of screen time do you have per day?
    - Any history of dry mouth/chronic fatigue/joint pain?
    - Any history of contact lens use?

Dry Eye F/U History – 8/24/22

- **Reason for Visit:** Follow Up
- **CC:** How have things been since your last visit? What symptoms are your experiencing? What seems to be bothering you the most? Dry eyes/foreign body sensation/decreased vision/fluctuating vision/itching/pain/tearing etc.
    - Both eyes?
    - Is one eye worse than the other?
- **Severity:** Are your symptoms stable, getting better, or getting worse?
- **Associated Symptoms:** List as appropriate
- **DED:** How often are you using artificial tears?
- **Extended HPI/Specialty Meds:** Review compliance with treatment plan and side effects

Glaucoma Evaluation History – 8/24/22

- **Reason for Visit:** Consultation if referred, New Patient if self-referred
- **CC Examples:**
    - Referred by Dr. * for Glaucoma Evaluation
    - Glaucoma Evaluation
    - Glaucoma Suspect Evaluation
- **Duration of Problem:** Have you ever been diagnosed with glaucoma? How long ago?
- **Associated Symptoms:**
    - Do you have blurry vision?
    - Do your eyes ever feel dry or uncomfortable?
- **Other:**
    - Do you have a family history of glaucoma?
    - Has any family member experienced blindness secondary to glaucoma?
    - Have you ever had an eye injury?
    - Have you ever had laser or surgery for glaucoma?
    - Are you currently taking eye drops?
    - Are you having any trouble with your drops?
    - How often do you miss your drops?
- **Pertinent Negatives: Record if applicable**
    - No change in vision
    - No discomfort

Glaucoma F/U History – 8/24/22

- **Reason for Visit:** Follow Up
- **CC Examples:** How have things been since your last visit? Any changes in vision or comfort?
    - Record new CC and F/U questions re: laterality/duration/severity/quality/associated symptoms/activity affected
    - If no new CC, use:
        - Glaucoma F/U
        - Glaucoma Suspect F/U
        - Ocular Hypertension F/U
        - IOP Check
- **Other:**
    - Are you having any trouble with your drops?
    - How often do you miss your drops?
- **Pertinent Negatives: Record if applicable**
    - No change in Vision
    - No discomfort
- **Extended HPI/Specialty Meds:** Review compliance with treatment plan and side effects

Medical Evaluation History – 8/24/22

- **Reason for Visit:** Consultation if referred, New Patient if self-referred
- **CC:** What brings you in today? Blurry vision, pain, referred by Dr. * for *, etc.
    - Both eyes?
    - Is one eye worse?
- **Duration of Problem:** How long has this bothered you?
- **Severity:**
    - How severe are your symptoms?
    - Are your symptoms stable, getting better, or getting worse?
    - Are your symptoms constant or do they come and go?
- **Modifying Factors:**
    - Is your vision worse with any specific activity or during a certain time of day?
    - Have you found anything that has been helpful in relieving your symptoms?
- **Associated Symptoms:**
    - Do your eyes ever feel dry or uncomfortable?
    - Does your vision ever fluctuate throughout the day?
    - Are you experiencing any other problems with your eyes?

Medical F/U History – 8/24/22

- **Reason for Visit:** Follow Up
- **CC:** How have things been since your last visit?
- **Severity:**
    - How severe are your symptoms?
    - Are your symptoms stable, getting better, or getting worse?
- **Associated Symptoms:** List as appropriate
- **Pertinent Negatives: Record if applicable**
    - No change in vision
    - No discomfort
- **Extended HPI/Specialty Meds:** Review compliance with treatment plan and side effects

Retina Evaluation History – 8/24/22

- **Reason for Visit:** Consultation if referred, New Patient if self-referred
- **CC:** What brings you in today? Blurry vision/decreased vision/distortion, Dr. X said I had AMD, etc.
    - Both eyes?
    - Is one eye worse?
- **Duration of Problem:** How long has this been a problem?
- **Severity:**
    - How severe are your symptoms?
    - Are your symptoms stable, getting better, or getting worse?
- **Modify Factors:**
    - Are your symptoms worse with any specific activity or during a certain time of day?
    - Have you found anything that has been helpful in relieving your symptoms?
- **Associated Symptoms:**
    - Do you have blurry vision (if not already addressed)?
    - Are you experiencing any other problems with your eyes?
- **Other:**
    - Do you have a family history of retina problems?
    - Have you ever had an eye injury?
    - Have you ever had laser or surgery for your eyes?

Retina F/U History – 8/24/22

- **Reason for Visit:** Follow Up
- **CC Examples:** How have things been since your last visit? Any changes in vision or comfort?
    - Record new CC and F/U questions re: laterality/duration/severity/quality/associated symptoms/activity affected
    - If no new CC, use:
        - AMD F/U
        - Diabetic Retinopathy F/U
        - Retina F/U
- **Pertinent Negatives: Record if applicable**
    - No change in vision
    - No discomfort

YAG Capsulotomy Evaluation History – 8/24/22

- **Reason for Visit:** YAG Evaluation
- **CC:** What brings you in today? Blurry vision/decreased vision/glare, Dr. X said I needed a laser, etc.
    - Both eyes?
    - Is one eye worse?
- **Duration of Problem:** How long has this bothered you?
- **Severity:**
    - How severe are your symptoms?
    - Are your symptoms stable or getting worse?
- **Modifying Factors:**
    - Is your vision worse with any specific activity or during a certain time of day?
    - Have you found anything that has been helpful in relieving your symptoms?
- **Associated Symptoms:**
    - Are you experiencing any other problems with your eyes?
- **Activity Affected:** Does your vision interfere with your everyday life? In what way?