This is a sample, representative template, normally used in clinics. It can be fully customised as per requirement.

Doctor Name

MBBS
OPHTHALMOLOGY

Your Hospital Name, Street Name,
Locality, Area, City, State, Pincode: 100XXX

+91-98XXXXXXX1

myemailid@gmail.com

Patient Name : **Date :**

UHID No. : **Age / Gender :** **Mob.:**

HTN:

DM:

IHD:

Asthma:

Drugs:

Vn < (RE) (LE)

c̄ PH < (RE) (LE)

IOP < (RE) (LE)

PGP < (RE) (LE)

Investigations:

- [ ] CBC
- [ ] BSL F/PP
- [ ] RFT
- [ ] LFT
- [ ] Urine R & M
- [ ] HIV
- [ ] HbsAg
- [ ] ECG
- [ ] Chest X-Ray
- [ ] Mantoux Test
- [ ] Sr. Homocysteine
- [ ] Sr. Lipid Profile
- [ ] MRI B + O
- [ ] Fitness Certificate

ANTERIOR SEGMENT: Right Eye Left Eye

FUNDUS: Right Eye Left Eye

DIAGNOSIS:

ADVICE:

Eye	Right			Left		
Vn	6 /			6 /		
	Sph	Cyl	Axis	Sph	Cyl	Axis
Distance						
Near						

Next Visit

DD / MM / YYYY

Date: DD / MM / YYYY

Next Visit

DD / MM / YYYY

Diagnosis: ______________________________

This is a sample, representative template, normally used in clinics. It can be fully customised as per requirement.

Doctor Name

MBBS
OPHTHALMOLOGY

Your Hospital Name, Street Name,
Locality, Area, City, State, Pincode: 100XXX

+91-98XXXXXXX1

myemailid@gmail.com

Patient Name : **Date :**

UHID No. : **Age / Gender :** **Mob.:**

	RE	LE
VA		
AR		
DRY		

Presenting Complaints :

- ☐ Itching
- ☐ Watering
- ☐ Redness
- ☐ N.V.
- ☐ Burning
- ☐ Irritation
- ☐ Stickiness
- ☐ Pain
- ☐ Headache
- ☐ D.V.
- ☐ Heaviness
- ☐ Dryness

RE **LE**

	RIGHT				LEFT			
	SPH	CYL	AXIS	VISION	SPH	CYL	AXIS	VISION
D.V.								
N.V.								

Next Visit

DD / MM / YYYY

Next Visit

DD / MM / YYYY

This is a sample, representative template, normally used in hospitals. It can be fully customised as per requirement.

Doctor Name

MBBS, MD
Ophthalmologist

Your Hospital Name, Street Name,
Locality, Area, City, State, Pincode: 100XXX

+91-98XXXXXXX1

myemailid@gmail.com

Patient Name :

UHID No :

Date/Time :

Age/Gender:

Mobile No. :

LAB TESTS ADVISED:

- ☐ Test 1
- ☐ Test 2
- ☐ Test 3
- ☐ Test 4
- ☐ Test 5
- ☐ Test 6
- ☐ Test 7
- ☐ Test 8
- ☐ Test 9
- ☐ Test 10
- ☐ Test 11
- ☐ Test 12

Other Lab Tests

IMAGING TESTS ADVISED:

- ☐ Test 1
- ☐ Test 2
- ☐ Test 3
- ☐ Test 4
- ☐ Test 5
- ☐ Test 6
- ☐ Test 7
- ☐ Test 8
- ☐ Test 9
- ☐ Test 10
- ☐ Test 11
- ☐ Test 12

Other Imaging Tests

Height ________cms **Weight** __________Kg **BMI** ______________ **Temp.** ________F

Pulse _________/min **R** _________/min **B.P.** _________mmHg **Pain Score** ________(0-10)

Fall Risk: ☐ Yes ☐ No **Nutritional Status:** ☐ Adequate ☐ Inadequate **Allergy:** __________

COMPLAINTS: ____

____

____

____

HISTORY OF OTHER DISEASES: ☐ Diabetes Mellitus ☐ Hypertension ☐ IHD ☐ Thyroid ☐ Tuberculosis ☐ Asthma

Vn (UA): <

C̄ PH <

	RIGHT				LEFT			
	SPH	CYL	AXIS	Vision	SPH	CYL	AXIS	Vision
Distance								
Near								
Intermediate								

☐ Constant Use ☐ Bifocals ☐ Near Only ☐ Progressive ☐ Two Separate Glasses

ANTERIOR SEGMENT:	RIGHT EYE	LEFT EYE
PHORIA / TROPIA / OCULAR MOTILITY		
LID		
CONJUNCTIVA		
CORNEA		
ANT. CHAMBER		
IRIS		
PUPIL		
LENS		
ROPLAS		
LACRIMAL SYSTEM:		
IOP:		

FUNDUS:	RIGHT EYE	LEFT EYE

Admission Advised: If Yes ______ **Surgery Advised:** If Yes ______

Procedure Advised: If Yes ______

Observation & Notes: ______

Additional Notes: ______

Medicine Name (IN CAPITALS)	Dose	Morning	Noon	Night	Days

Doctor's Seal & Signature

Acute

Chronic

FOLLOW UP DATE

DD / MM / YYYY

This is a sample, representative template, normally used in hospitals. It can be fully customised as per requirement.

Doctor Name

MBBS, MD
Ophthalmologist

Your Hospital Name, Street Name,
Locality, Area, City, State, Pincode: 100XXX

+91-98XXXXXXX1

myemailid@gmail.com

Patient Name : **UHID No** :

Date/Time : **Age/Gender:** **Mobile No. :**

COMPLAINTS:

H/O : Dm

H/O : HT

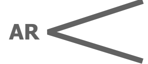
H/O : IHD

H/O : Thyroid

H/O : TB

H/O : Asthma

Vn (UA): **Nv (UA):** **Aided** **C̄ PH**

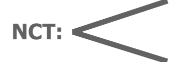
AR 

P.G.P

OD				**OS**			
	Sph	Cyl	Ax		Sph	Cyl	Ax
DIST							
ADD.							

ACCEPT

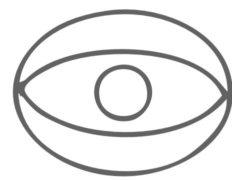
OD				**OS**			
	Sph	Cyl	Ax		Sph	Cyl	Ax
DIST							
NEAR							

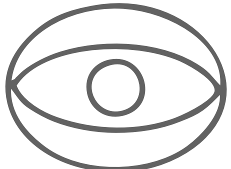
NCT: 

APPLN:

SLIT LAMP EXAMINATION:

ANTERIOR SEGMENT:





PHORIA / TROPIA

LID

CONJUNCTIVA

CORNEA

ANT. CHAMBER

IRIS

PUPIL

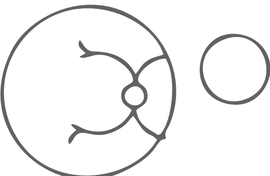
LENS

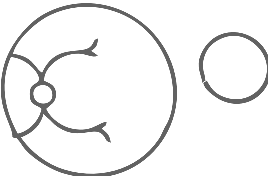
OCULAR MOVEMENTS

LACRIMAL SYSTEM:

FUNDUS: UNDILATED :

DILATED :





GONIO:

PRESCRIPTION

Date	MEDICINE (WRITE IN CAPITAL)	Dose	Morn	Noon	Night	Days	Instructions
DD / MM / YYYY							Before Food After Food
DD / MM / YYYY							Before Food After Food
DD / MM / YYYY							Before Food After Food
DD / MM / YYYY							Before Food After Food
DD / MM / YYYY							Before Food After Food
DD / MM / YYYY							Before Food After Food

Admission Advised: If yes

Surgery Advised: If yes

Pre Operative Profile: If yes

Consultant Seal & Signature

FOLLOW UP DATE

DD / MM / YYYY