GLAUCOMA ASSESSMENT

Date:

Patient Details	Diagnosis
	Reason for referral IOP VF Disc FHG NA Other:
Referred By	<u>Ocular History</u>
<u>History & Symptoms</u> Headaches/Haloes? Other:	<u>Medication</u>
<u>General Health</u> CVA/MI COAD/Asthma Diabetes Hypertension Migraine Steroids Raynauds Other:	<u>Allergies</u>
<u>Social History</u> Smoker Driver Occupation:	<u>Family History</u>
Distance Rx	
RE	LE

	RIGHT	LEFT
Visual Acuity Pin Hole		
Ocular Adnexa		
Pupil Reactions		
IOP@ _____		
Pachymetry		
Gonioscopy		
Cornea		
Anterior Chamber		
Iris		
Lens		
Dilated	Yes / No Time:	
Disc Drawing		
Disc Photographs	Yes / No	
OCT		
Fundus		
Visual Field		
Provisional Diagnosis		
Management		
Review		

Examiner: ____