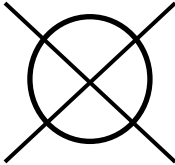
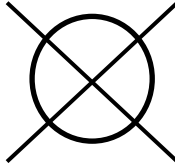


GLAUCOMA ASSESSMENT		Date:
Patient Details	Diagnosis	
	Reason for referral	
Referred By	IOP VF Disc FHG NA	
	Other:	
<u>History & Symptoms</u>		<u>Ocular History</u>
Headaches/Haloes?		<u>Medication</u>
Other:		
<u>General Health</u>		
CVA/MI	COAD/Asthma	<u>Allergies</u>
Diabetes	Hypertension	
Migraine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