American Surgery Center

YOUR AMBULATORY SURGERY CENTER IN WILMINGTON, DE

OPHTHALMIC HISTORY AND PHYSICAL FORM

To be completed by examining physician.

Patient Name _____

Address _____

Examining Physician _____ Date of Operation _____

History of Present Illness _____

_____

_____

Past Ocular History _____

_____

_____

Physical Examination

Age _____ Best Corrected Vision: OD _____ OS _____

External _____

Pupils _____

Visual Fields _____

Motility _____

Tension _____

Slit Lamp _____

_____

Fundus _____

_____

Other _____

Diagnosis _____

Indications for Surgery (How are activities of daily living affected?) _____

_____

Proposed Surgical Procedure _____

_____

_____ _____

Signature of Examining Physician ***Date***

PATIENT LABEL