

شماره پذیرش:

تاریخ:

سن:

نام و نام خانوادگی:

1. Chief Complaint:

2. Present Illness:

3. Past Ocular History:

4. General Medical History:

5. Family History:

6. Allergies:

7. Present Medications:

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OD

OS

GE:

1. Visual Acuity

SC:

CC:

PH:

2. Deviation

3. EOM

4. Red Reflex

5. Pupillary Reflex

6. RAPD

SC:

CC:

PH:

SLE:

1. Lacrimal System

2. Eyelids & lashes

3. Conjunctiva

4. Cornea

5. AC

6. Angle

7. Iris

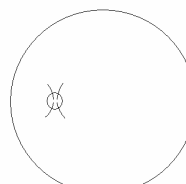
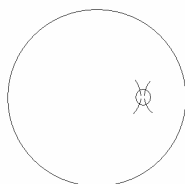
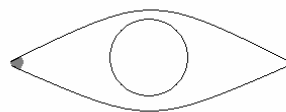
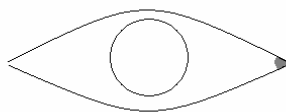
8. Lens

9. Ant. Vitreous

IOP:

Refraction:

Funduscopy:



Impression:

Plan:

Signature:

تاریخ مراجعه بعدی:

در مراجعه بعدی این برگه را همراه داشته باشید

Remark: