



Patient record: Ophthalmology

Blank form to fill in by hand.

Clinic

Doctor

Date

____ / ____ / ____
dd/mm/yyyy

Essentials

First name

Last name

Date of birth

____ / ____ / ____
dd/mm/yyyy

Place of birth

Nationality

Profession

Phone number

Email

Address

Gender

☐ Female ☐ Male ☐ Non binary ☐ Prefer not to say

1. Reason for Visit

Presenting complaint

Affected eye

☐ Right ☐ Left ☐ Both

Do you wear glasses or contact lenses?

☐ Yes ☐ No

If yes, give details:

2. Visual Acuity

Visual acuity

Eye	Uncorrected	Corrected	Pinhole

3. Refraction

Refraction

Eye	Sphere	Cylinder	Axis	Add

4. Examination

Intraocular pressure

Date	OD (mmHg)	OS (mmHg)

Anterior segment

Fundus examination

Fundus photograph

Space for a photo or sketch

5. Medical History

Glaucoma?

☐ Yes☐ No

If yes, give details:

Diabetes?

☐ Yes☐ No

If yes, give details:

Previous eye surgery?

☐ Yes☐ No

If yes, give details:

Family history of eye disease?

☐ Yes☐ No

If yes, give details:

Drug allergies?

☐ Yes☐ No

If yes, give details:

Current medications

6. Diagnosis and Plan

Diagnosis

Prescription and treatment plan

7. Consent

Informed consent

1. I have been informed in an understandable way about my diagnosis, the purpose of the proposed treatment, the procedures that may be performed, reasonable alternatives, expected benefits, limitations and possible risks.
2. I have been informed that the outcome of treatment cannot be guaranteed absolutely and that additional procedures, check-ups or treatment may be needed depending on the clinical situation.
3. I have had the opportunity to ask questions, and I declare that the answers I received were sufficient for my decision.
4. I authorize the ophthalmologist and clinical staff to perform the agreed treatment and clinically necessary supporting procedures within the treatment plan discussed with me.
5. I have been informed that I have the right to refuse the treatment or to withdraw this consent at any time. Withdrawal does not affect procedures performed before it.

Patient or Legal Representative Signature

Doctor Signature

Date:

Date:

Signature

Date _____

____/____/____
dd/mm/yyyy