EXAMINATION REPORT

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DOB: 12/30/1961 For: Test, Ima Age: 43

PATIENT HISTORY

OCULAR HISTORY:

Adie's Pupil. Denies amblyopia, strabismus, ocular injuries or surgeries. Denies prior visual field loss/constriction, glaucoma, cataracts, and macular degeneration.

Exam Date: 09/10/2005

MEDICAL HISTORY:

Admits hypertension (longstanding; fair control with medications), thyroid disease. Denies diabetes, heart disease, lung disease, cancer, inflammatory disease and infectious disease.

FAMILY HISTORY:

Patient denies pertinent family history including blindness, glaucoma, macular degeneration and retinal detachment. In addition, pertinent systemic family history is unremarkable.

SOCIAL HISTORY:

Tobacco usage - Current smoker, 2 pks day.

CURRENT MEDICATIONS:

Atenolol Multivitamin Synthroid **ALLERGIES:**

Penicillin

SUBJECTIVE

43 vo WM

ENCOUNTER TYPE: Intermediate eye exam. Refraction. Contact lens evaluation.

PATIENT TYPE: New Patient

LAST EXAM: Two years ago. (Dr Jones Office in Rockford)

CHIEF COMPLAINT: Updating spectacle Rx. Wears spectacles full-time. With spectacles... vision seems stable. Wants new frames.

OCULAR SYMPTOMS: Patient denies double vision, flashes, floaters or other ocular symptoms of clinical significance.

MEDICAL HX: Medical/Personal History from 09/10/05 reviewed.

OBJECTIVE

INSTRUMENT READINGS:

AUTOREFRACTION:

OD +1.25 -0.75 x 157

OS +1.00 -0.50 x 034 Vertex=13.75 mm

AUTOKERATOMETRY:

OD 41.75 / 43.00 @ 078 OS 41.50 / 42.75 @ 100

NON-CONTACT TONOMETRY:

OD 16.0 mm

OS 13.0 mm @ 0446 pm

AUTOLENSOMETRY:

OD -0.75 -0.50 x 074

OS -1.00 -0.50 x 080 Add +1.50 (BF)

AUTOLENSOMETRY: (SUN Rx)

OD -9.75 sph

OS -6.25 -0.50 x 092

REFRACTIVE FINDINGS:

ENTERING ACUITY: ccDVA

OD 20/25 OS 20/20--

SUBJECTIVE REFRACTION:

OD -2.25 -0.50 x 074 20/20 OS -2.00 -0.50 x 080 20/20

OU 20/20 (Binocular Balanced) Add +1.50 20/20 @ 16"

REFRACTIVE NOTE - Difficult subjective endpoint.

FINAL Rx:

OD -2.25 -0.50 x 074

OS -2.00 -0.50 x 080 Add +1.50

EXAMINATION FINDINGS:

NEURO Patient is fully alert to time, place and person. Recent and remote memory is fully intact. Patient does not appear anxious or depressed.

ADNEXA/EYELIDS Facial symmetry, ocular adnexa (including eyelids, eyelashes, and lacrimal glands) were found to be normal OU. In addition, each eye is free of pertinent surface lesions.

VISUAL FIELDS Confrontation testing confirms satisfactory peripheral visual fields OD and OS.

EOMS Full, extensive, accurate and smooth movements are observed OU.

COVER TEST A small (intermittant) exotropia is noted at near. Testing done without correction.

PUPILS Reacted briskly (3+) to direct and consensual stimuli; pupil size is normal, equal and round OU. There is no afferent pupillary defect.

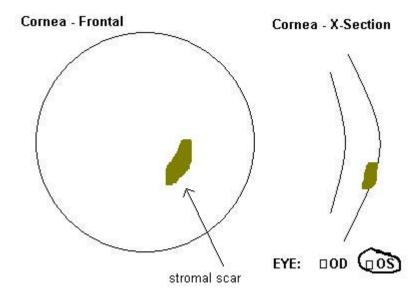
ANTERIOR SEGMENT:

LIDS/LASHES Clear OU.

SCLERA Clear OU.

CONJUNCTIVA Bulbar and palpebral conjunctiva are white, clear and without signs of inflammation.

CORNEA Slit lamp examination reveals... endothelial pigment deposits noted OS>OD. Scar defect noted on corneal surface OS. No ulceration or infiltration noted OU.



IRIS Healthy with normal anatomy and convexity.

ANTERIOR CHAMBER Slit lamp examination noted chambers of normal depth and without signs of cells or flare.

ANGLE ESTIMATE Grade 2+, moderately narrow angle OU. Angle evaluation indicates some risk for dilation.

LENS Slit lamp examination reveals no pertinent cataract formation or opacities.

GOLDMANN TONOMETRY:

OD 14.0 mm

OS 15.0, 17.0 mm @ 0145 am

POSTERIOR SEGMENT:

OPTIC DISC Normal color, size and shape with intact neuro-retinal rims 360 degrees. Flat and sharp borders noted, as well as grossly normal appearance of nerve fiber layer OU.

CUP/DISC RATIO OD 0.50 H/V; OS 0.60 H/V Temporal sloping OD. Peripapillary atrophy OU.

VITREOUS Vitreous body is clear OU.

MACULA Bilateral examination reveals maculae of normal thickness, free of atrophic changes.

VASCULATURE Vasculature does not show hemorrhages or exudates. Normal A/V crossings observed OU.

POSTERIOR POLE Normal fundus coloration, retinal thickness and architecture observed within the primary arcades OU.

PERIPHERAL RETINAL No breaks, tears, lesions or retinal detachments visible 360 degrees OU.

[Dilated fundus examination using 1 drop tropicamide 1% and phenylephrine 2.5%, evaluated with 78D lens and 20D BIO lens and . Patient warned of effects of dilating drops.]

ASSESSMENT

367.1 Myopia

367.4 Presbyopia

378.11 Exotropia, Monocular

371.02 Corneal Opacity, Peripheral - OS

371.13 Corneal Pigmentation, Posterior (Krukenberg Spindle) - OU

365.02 Glaucoma Suspect, Anatomical Narrow Angle

PLAN

REFRACTIVE PLAN:

OD -2.25 -0.50 x 074

OS -2.00 -0.50 x 080 Add +1.50

CONTACT LENS PLAN: Trials dispensed for evaluation. New wearer; I&R training required.

OD Vistakon Acuvue 8.4 / -2.50 / 14.0 OS Vistakon Acuvue 8.4 / -2.25 / 14.0

OCULAR TREATMENT PLAN:

- (1) CORNEAL OPACITY Monitor condition.
- (2) CORNEAL PIGMENTATION Baseline visual fields today. Monitor condition for changes.
- (3) NARROW ANGLES Defer surgical intervention at the present time.

PATIENT EDUCATION: Discussed importance of regular eye exams. Discussed risks of angle closure with patient; educated patient on signs/symptoms of angle closure attack.

RECOMMENDED FOLLOW-UP

F/u in 1-2 weeks for CL progress eval. Eye exam in 1 year.

Signed by: DJP Print Date: 09/13/2005

NOTE: The information in this report in confidential. Unauthorized disclosure may result in civil and/or criminal penalties as provided by Health Insurance Portability and Accountability Act (HIPAA) of 1996 regulations.