TELEMEDICINE

Patient's **First Name**:✍________________________ **Last Name**:______________________________

Birthdate: m______/d________/y__________ **Today's date** ____/_____/_________

cell phone # (_______)________-_________ email:____

Name of ❐parent / ❐guardian or ❐ who is sending the Telemedicine Exam: ______________________________

Health History:

Main Problem/Concern with Vision:____

When did it start?____

How bad is it?____

What makes it worse?_____________________________________

What makes it better?______________________________________

❐ New Referral or ❐Follow-up

Your doctor / local health-care provider(s)? ______________________________________

Any current treatments for the eye(s)?______________________________

Glasses?: __________________

Any other Health Problems?:

Explain any Injury to the eyes?_____________________________

Any surgery related to the eyes?________________________

Any family problems related to the eyes?___________________

Your Examination of the EYES and VISION:

❐ Home Acuity Screen : right eye: **20/**_________ left eye: **20/**__________

❐ If you can get a **photoscreen** from local clinic / nurse / Lion's Club, send results.

❐ Cell phone photograph(s) showing what concerns you about the eye(s).

❐ Cell phone video showing eye alignment or concerns.

Comments:

http://www.abcd-vision.org/abcd-clinics/Telemedicine.html