

**Nom De Famille:** \_\_\_\_\_ **Prenom:** \_\_\_\_\_ **Date De Naissance: (J/M/A)** \_\_\_\_\_

**Sexe:** H/F **L'Age:** \_\_\_\_\_ **Paran (pou timoun) oswa yon kontak ijans** \_\_\_\_\_ **Telefòn** \_\_\_\_\_  
Parent (for children) or emergency contact

**Adresse:** \_\_\_\_\_ **Telefòn** \_\_\_\_\_

**HX (Circle) HTN DM Seizures Asthma Anemia GERD Other:** \_\_\_\_\_

**Glasses:** Near Far **Eye Surgery:** \_\_\_\_\_ **Eye Injury** \_\_\_\_\_

**Medications:** \_\_\_\_\_

**EXAM DATE:** \_\_\_\_\_ **Do you use eye drops? Oui/Non** \_\_\_\_\_ **Which eye? OU OD OS**  
*Ou itilize gout je? ki je?*

<b>VA</b>	<b>with glasses</b>	20/_____ OD	<b>VA</b>	<b>without glasses</b>	20/_____ OD
	ak linèt	20/_____ OS		san yo pa linèt	20/_____ OS

**Can they count fingers? CF**  
*Èske yo konte dwèt ?*

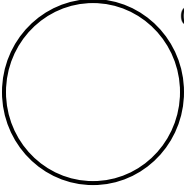
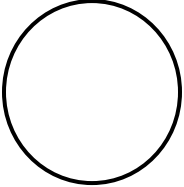
**Can they see a hand move? HM**  
*Èske yo wè yon mouvman men?*

**Can they see light? LP**  
*Èske yo wè limyè ?*

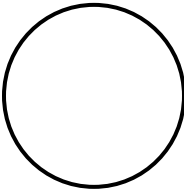
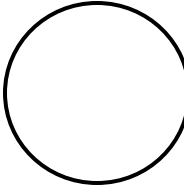
**IOP**                      **OD**                      **OS**                      **Not Done**

**PUPILS:** \_\_\_\_\_ **EOM:** \_\_\_\_\_

**ANTERIOR SEGMENT**

	<b>OD</b>		<b>OS</b>
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**FUNDI**

	<b>OD</b>		<b>OS</b>
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**Assessment:**

**Plan:**

**Retounen nan klinik (return to Clinic)**

**Dokté** \_\_\_\_\_

**Nom De Famille:** \_\_\_\_\_ **Prenom:** \_\_\_\_\_ **Date De Naissance: (J/M/A)** \_\_\_\_\_

**EXAM DATE:** \_\_\_\_\_ **Do you use eye drops? Oui/Non**  
*Ou itilize gout je?*

**Which eye? OU OD OS**  
*ki je?*

**VA with glasses** 20/\_\_\_\_OD  
*ak linèt* 20/\_\_\_\_OS

**VA without glasses** 20/\_\_\_\_OD  
*san yo pa linèt* 20/\_\_\_\_OS

**Can they count fingers? CF**  
*Èske yo konte dwèt ?*

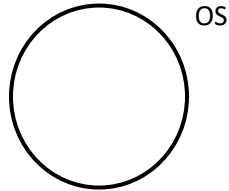
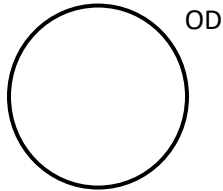
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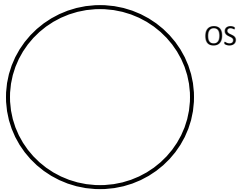
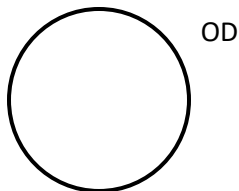
**IOP**                      OD                      OS                      Not Done

**PUPILS:** \_\_\_\_\_ **EOM:** \_\_\_\_\_

**ANTERIOR SEGMENT**



**FUNDI**



**Assessment:**

**Plan:**

**Retoune nan klinik (return to Clinic)**

**Dokté** \_\_\_\_\_