DAVID D. RICHARDSON, MD, INC.

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Glaucoma Screening Intake

Patient's Name: _____ Phone Number: _____

Mailing Address: _____ Email Address: _____

Age: _____ Sex: _____ Ethnicity: _____

BRIEF CONSENT (Kindly sign and date)

I understand that this is a screening and is not a medical exam. I am also aware that a diagnosis cannot be made with screening alone. Recommendations based on this screening are limited to roughly gauging my risk of developing glaucoma and are not to be considered medical treatment. If the screening determines that I am at risk for developing glaucoma I understand that it is important for me to schedule a complete eye exam with glaucoma testing with an ophthalmologist.

_____ _____

Signature **Date**

QUESTIONS

	YES	NO
Do you have anyone in your family with glaucoma or high eye pressure?	☐	☐
Have you ever been told that your eye pressure was high?	☐	☐
Are you (or have you ever been) nearsighted?	☐	☐
Do you have diabetes?	☐	☐
Do you have sleep apnea?	☐	☐
Do you have high blood pressure?	☐	☐
If female: Do you use (or have you ever used) the birth control pill?	☐	☐

If so, for how long have you used it? _____

TO BE FILLED UP BY DR. RICHARDSON AND TEAM. DO NOT FILL BELOW THIS LINE

TEST RESULTS

Tonometry:

RE _____ LE _____

[ ] Tonopen [ ] GAT [ ] iCare

Pachymetry:

RE _____ LE _____

IMPRESSION

☐ Low ☐ Moderate ☐ High glaucoma risk

RECOMMENDATIONS

☐ Visual field testing (FDT or HVF)

☐ Optic Nerve scanning

☐ Gonioscopy

☐ Dilated exam

☐ Given glaucoma patient information handout