Diabetic Evaluation Report

Patient Name: _____ **D.O.B.**_____

Primary Doctor: _____

Consultant Optometrist: _____

Date: _____/_____/_____

Duration of Diabetes: _____

Medication (s) for Diabetes: _____

Most recent A1C: _____% □ **unknown to patient**

Best Corrected Acuity: **Right: 20/** _____ **Left: 20/**_____

Slit Lamp Exam: **Normal:** _____

Other: _____

Dilated Fundus Exam: **No Diabetic Retinopathy** □ **OD** □ **OS**

Other: _____

_____

Recheck: □ **Annually**

□ **Other:** _____

Comments:

Thank you very much for entrusting your patient to us for their eye care.