The Medical Eye Center
Dr. Gagan J. Singh, M.D.
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PATIENT SUMMARY FORM

Patient Name: _____ Date: _____

Date of Last Exam: _____

VAs			**IOP**	
	OD	**OS**	**OD_____mmHg**	**OS_____mmHg**
SC	**20/**	**20/**		
CC	**20/**	**20/**		

Spectacle RX:

OD _____ _____ X _____ ADD_____ 20/

OS _____ _____ X _____ADD_____ 20/

CLs RX:

	B/C	**DIA**	**POWER**	**BRAND**
OD	**____**	**_____**	**_____**	**_____**
OS	**____**	**_____**	**_____**	**_____**

Medical History: _____

_____

Summary of Ocular Findings:_____

_____

_____

_____

_____

ATTATCHED: GDX _____ OCT _____ VISUAL FIELD _____

OTHER_____

If further detailed notes are needed, please contact our office.

Regards,

_____
Gagan J. Singh, M.D.