EYE COMPLAINTS

Reference: Assessment Made Incredibly Easy: 2nd Edition, 3 minute Assessment, Patient Care Guidelines for Nurse Practitioners

ALLERGIES:

Date: **Time:**

SUBJECTIVE

CC/Onset:

Itching: ☐ N ☐ Y
Discharge: ☐ N ☐ Y color:
Blind spots: ☐ N ☐ Y

Light sensitive: ☐ N ☐ Y
Vision: ☐ Normal ☐ Blurry
Floaters ☐ N ☐ Y

☐ Pain Describe: (10 – scale)

Significant past medical history: ☐ Eye surgery ☐ Cataracts ☐ Retinal detachment ☐ Eye glasses ☐ Contacts

LMP: UPT Results: Date:

OBJECTIVE

T:	P:	R:	BP:	SaO2:	FSBS:

General appearance: Weight:_____

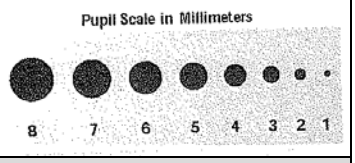
Visual Acuity: R_____ L_____ Both_____

Pupil size: R _____mm L _____mm **Equal and reactive to light:** ☐ Y ☐ N Describe_____

Cornea color: ☐ White ☐ Red ☐ Yellow **Edema** ☐ N ☐ Y **Excessive blinking** ☐ N ☐ Y **Excessive tearing** ☐ N ☐ Y

Suspect foreign body ☐ N ☐ Y _____

Other pertinent findings:



ASSESSMENT

1. Foreign body to eye 2. Corneal abrasion 3. Conjunctivitis 4. Drainage

PLAN

☐ Fluoroscein stain, if suspected corneal abrasion or foreign body

☐ Visual acuity

☐ Contact Provider for further orders

☐ Other_____

EDUCATION

1. Do not rub eyes
2. Follow Provider orders
3. Follow up as directed by Provider
4. If placed on medications do not share
5. Teach medication administration
6. Ambulate with caution

Staff Signature/Title	**Date/Time**

After being seen today, I will receive the above medications and treatments. I understand my responsibility for care.

_____*Inmate Signature*

Name:	DOB:
ID:	Location:
Race: B W H A other	Sex: M F T

NAME: **DOB:**

PROGRESS NOTES

Date/ Time	