GLAUCOMA FLOW SHEET

Name: _____ Date & Medication_____
Fm. Hx._____ _____
Allergies _____ _____
Medical Hx: Respiratory Problems: _____
_____ _____
Diabetes_____ _____
Elev. Chol._____ _____
Heart Problems _____ _____
Physician _____ _____
Initial TN:RE_____ Goal TN:RE_____ _____
LE_____ LE_____ _____

Date	Time	VA	PH	IOP	Target IOP	Last Gtts.	VF	Disc	Scanning Laser (GDX/HRT)	Gonio	Follow-Up

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