GLAUCOMA FLOW SHEET

Name: ______________________________
Fm. Hx.______________________________
Allergies ____________________________
Medical Hx: Respiratory Problems:
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Diabetes_____________________________
Elev. Chol.___________________________
Heart Problems _______________________
Physician ____________________________
Initial TN:RE______ Goal TN:RE______
LE______ LE______

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