

PLAQUENIL EYE EVALUATION REPORT

Date _____

Patient Name _____ DOB _____

Prescribing Doctor _____ Fax # _____

Consulting Optometrist _____

Plaquenil dose _____mg _____ Patient's weight _____

Visual acuity: right eye 20/_____ left eye 20/_____

Slit lamp exam: Normal _____ Other _____

Fundus exam: Normal _____ Other _____

Macular Visual field Testing (10-2): Normal _____ Other _____

Recheck: 1 year _____ Other _____

Comments: _____

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