

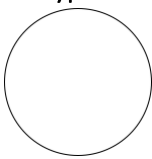
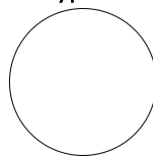
# PATIENT FORM – 170

**Patient Number** 170      **Gender** Male | ប្រុស  
**Family Name** Kheng Yary      **Given Name/s:** {Given Name/s:  
 (KH/EN):6}  
**Age** 60      **Patient has TB:** No  
**Province** Phnom Penh      **District:** Chbar Ampov  
**Village** NA      **Commune:** NA  
**Reason for visit** Pterygium | ភ្នែកឡើងបាយ  
 Eyes Blurry Distance | មើលឆ្ងាយព្រិល  
 Eyes Blurry Reading | មើលជិតព្រិល  
 Eyes Itchy (Left) | រមាស់ភ្នែក ឆ្វេង  
 Eyes Pain/Discomfort (Left) | ឈឺភ្នែក ឬ រកាំ (ឆ្វេង)  
 ហឹងត្រចៀក  
 Cholesterol | លើសជាងខ្លាញ់  
 គ្រោះក្នុងតម្រងនោម ទឹកនោមប្រៃ  
**Mobile Number** 068927666

R

L

## PRE-SCREENING

|                                                                                    |    |        |                                                                                     |          |    |
|------------------------------------------------------------------------------------|----|--------|-------------------------------------------------------------------------------------|----------|----|
| UNAIDED / AIDED VA                                                                 |    | RE 6/  |                                                                                     | LE 6/    |    |
| PINHOLE VA                                                                         |    | RE 6/  |                                                                                     | LE 6/    |    |
|                                                                                    | RE | LE     | RE                                                                                  | LE       | RE |
| IOP                                                                                |    |        |                                                                                     |          |    |
| TIME                                                                               |    |        |                                                                                     |          |    |
| ANTI-GLAUCOMA TX                                                                   |    | DIAMOX |                                                                                     | ALPHAGAN |    |
|                                                                                    |    |        |                                                                                     | COMBIGAN |    |
| AUTO-Ks                                                                            |    | RE 6/  |                                                                                     | LE 6/    |    |
| AUTO Rx                                                                            |    | RE 6/  |                                                                                     | LE 6/    |    |
| R – Type of Cataract                                                               |    |        | L – Type of Cataract                                                                |          |    |
|  |    |        |  |          |    |
| R Posterior                                                                        |    |        | L Posterior                                                                         |          |    |
| <input type="checkbox"/> R CATARACT EXTRACTION                                     |    |        | <input type="checkbox"/> L CATARACT EXTRACTION                                      |          |    |
| <input type="checkbox"/> R PTERYGIUM                                               |    |        | <input type="checkbox"/> L PTERYGIUM                                                |          |    |
| <input type="checkbox"/> R TRACHOMA REPAIR                                         |    |        | <input type="checkbox"/> L TRACHOMA REPAIR                                          |          |    |
| <input type="checkbox"/> R OTHER SURGERY                                           |    |        | <input type="checkbox"/> L OTHER SURGERY                                            |          |    |
| Optomo Initials                                                                    |    |        |                                                                                     |          |    |

REFRACTION



|                                            |       |                                                                  |       |       |
|--------------------------------------------|-------|------------------------------------------------------------------|-------|-------|
| SUBJ Rx                                    | RE 6/ | Add +                                                            | LE 6/ | Add + |
| <input type="checkbox"/> GLASSES DISPENSED |       | <input type="checkbox"/> PRESCRIPTION GIVEN FOR UPDATE ELSEWHERE |       |       |
| Other Comments:                            |       |                                                                  |       |       |

# PATIENT FORM – 170

## Medical History

|                               |  |                 |            |                     |  |
|-------------------------------|--|-----------------|------------|---------------------|--|
| Heart Disease including       |  |                 |            |                     |  |
| Chest Pain                    |  | Hypertension    |            | Shortness of breath |  |
| Respiratory History including |  |                 |            |                     |  |
| Asthma                        |  | Cough           |            | COPD                |  |
| Metabolic History including   |  |                 |            |                     |  |
| Diabetes                      |  | Thyroid Disease |            | Kidney Failure      |  |
| Infections including          |  |                 |            |                     |  |
| Skin                          |  | HIV             |            | Hepatitis           |  |
| Additional History            |  |                 |            |                     |  |
| Medications                   |  |                 | Operations |                     |  |
| Mental Health                 |  |                 | Allergies  |                     |  |

## Tests

|               |  |             |  |                 |  |
|---------------|--|-------------|--|-----------------|--|
| O2 Saturation |  | Temperature |  | Fasting Glucose |  |
| BP            |  | Pulse Rate  |  | Heart Sound     |  |
| Other tests:  |  |             |  |                 |  |
| CXR           |  | E.C.G.      |  | Blood test      |  |

## Clinical Examination

|                       |  |             |  |                  |  |
|-----------------------|--|-------------|--|------------------|--|
| CVS                   |  | Respiratory |  | Anaemic/Jaundice |  |
| Medications Dispensed |  |             |  |                  |  |

## Surgery Status

|                                  |  |                            |  |
|----------------------------------|--|----------------------------|--|
| Can lay down for an hour         |  | Is patient fit for surgery |  |
| Patient needs to be reviewed for |  |                            |  |

## Consent to Eye Examination – Treatment – Surgery

Patient, Parent or Guardian was asked in the Khmer language if they agree/consent to examination and treatment of their eyes, or child's eyes, including placing of drops in to the eye and surgery if required, by the Cambodia Vision Ophthalmic Team. And in witness thereof Patient's or Guardian's signature or Mark/Thumb Print. All information is based on the persons Cambodian National Identity Card, where available, or oral enquiry of the person by the Cambodian registration team member.

Patient, Parent, or Guardian AGREES/CONSENTS to all of the above, Signed on 20/10/2024