

Hydroxychloroquine (Plaquenil) Evaluation

Patient Name _____ D.O.B. _____

Referring Physician _____

Consultant Optometrist _____

Date ____/____/____

Number of years taking HCQ _____

Plaquenil dose _____ mg _____

Patient's Weight _____ lbs.

Acuity Right 20/____ Left 20/____

Estimated Ideal Weight _____ lbs.

Height _____

Fundus exam Normal _____ Other _____

Macular Visual Field Testing (10-2) Normal _____ Other _____

SD-OCT Normal _____ Other _____

Recheck: Annually _____ Other _____

Comments:

Thank you very much for entrusting us with the eye care of your patient.