PROFORMA

Patients's name
Age and sex
Address

Case No.
CR/OPD No.
Eye R/L

HISTORY

a) Age at time of diagnosis of DM
b) Total Duration of DM

c) Nature of treatment
d) Compliance of treatment
   and adequacy of diet control
e) Regularity in monitoring urine
   and blood sugar,
f) Ocular symptoms and any treatment
   for the same
g) History of associated systemic
   diseases.
h) Family history of DM or diabetic
   retinopathy.

GENERAL PHYSICAL EXAMINATION

OPHTHALMIC EXAMINATION

1. Visual Acuity (aided)
2. Anterior Segment Examination
3. Fundus Examination
   a) Background changes
      1) Microaneurysms
         Number
         Distribution
      11) Retinal haemorrhages
         Number Distribution
         Size
         Deep
         Superficial
iii) Exudates: Number Distribution
   Size
   Hard
   Soft
iv) Changes in veins
v) Changes at arteriovenous crossing

b) Proliferative changes
   i) Neovascularisation
      Site
      Extent
   ii) Fibrous Bands
   iii) Changes in Vitreous
   iv) Retinal Detachment

SYSTEMIC EXAMINATION

F.A. FINDINGS

1. Microaneurysms
   Number
   Distribution
2. Leakage or pooling of dye
3. Shunt vessels
4. Changes in veins
5. Areas of retinal capillary non-perfusion
6. State of perifoveal capillary arcade
7. Changes in the arterioles
8. Area of blockage of choroidal fluorescence
9. Neovascularisation: Site
    Extent
10. Any other changes