

Eye Examination Report

Patient's Name _____ Date of Birth _____ Social Security No. _____

Address _____ City _____ State _____ Zip _____

Attention Eye Care Specialist

Address **each** item below.



Your thoroughness in completing this report is essential for this patient to receive appropriate services.



Ocular History (e.g., previous eye diseases, injuries, or operations)

Age of onset _____ History _____

Visual Acuity

If the acuity **can** be measured, complete this box using Snellen acuities or Snellen equivalents or NIL, LP, HM, CF.

Without Glasses		With Best Correction	
Near	Distance	Near	Distance
R	R	R	R
L	L	L	L

If the acuity **cannot** be measured, check the most appropriate estimation.

- Legally Blind
 Not Legally Blind

Acuity with glare testing, if applicable: R _____ L _____

Muscle Function Normal Abnormal Describe _____

Intraocular Pressure Reading R _____ L _____

Visual Field Test

- There is no apparent visual field restriction.
 There **is** visual field restriction. Describe _____
 Yes No The visual field is restricted to 20 degrees or less.

Color Vision Normal Abnormal **Photophobia** Yes No

Diagnosis (Primary cause of visual loss)

—OVER—

Prognosis

- Permanent
- Progressive

- Recurrent
- Communicable

- Improving
- Can Be Improved

- Unable to determine prognosis at this time

Treatment Recommended

Glasses

Patches (Schedule):

R _____

L _____

Medication _____

Refer for other medical treatment/exam:

Surgery

Low Vision Evaluation

Other _____

Precautions or Suggestions (e.g., lighting conditions, activities to be avoided, etc.)

Scheduling

Date of Next Appointment _____ Time _____

IMPORTANT

Check the most appropriate statement.

- This patient appears to have no vision.
- This patient **has a serious visual loss** after correction.
- This patient **does not have** a serious visual loss after correction.
- This patient **has** a medical diagnosis for a progressive condition that will result in no vision or a serious visual defect after correction.

Print or Type Name of Licensed Ophthalmologist or Optometrist

Signature of Licensed Ophthalmologist or Optometrist

Address

Date of Examination

City State Zip

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Telephone Number

RETURN COMPLETED FORM TO:

Name

Address

Agency

City State Zip

