

# Eye Examination Report

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

## ATTENTION EYE CARE SPECIALIST

Address **EACH** item below.

*Your thoroughness in completing this report is essential  
for this patient to receive appropriate educational 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, Snellen equivalents or NLP, LP, HM, CF.)

| Without Correction |          | 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.

Refraction OD \_\_\_\_\_

OS \_\_\_\_\_

☐ Legally Blind

☐ Not Legally Blind

### Muscle Function

☐ Normal

☐ Abnormal

Describe: \_\_\_\_\_

### Intraocular Pressure Reading

R: \_\_\_\_\_ L: \_\_\_\_\_

### Visual Field Test

☐ There is no apparent visual field restriction.

☐ The **is** a field restriction. Describe: \_\_\_\_\_

☐ The visual field **is** restricted to 20 degrees or less.

### Color Vision

☐ Normal

☐ Abnormal

☐ Unknown

Describe: \_\_\_\_\_

**Diagnosis** *(Primary cause of visual loss)*

---

---

**Prognosis**

- |                                      |                                    |                                          |
|--------------------------------------|------------------------------------|------------------------------------------|
| <input type="checkbox"/> Permanent   | <input type="checkbox"/> Recurrent | <input type="checkbox"/> Can Be Improved |
| <input type="checkbox"/> Progressive | <input type="checkbox"/> Stable    | <input type="checkbox"/> Improving       |

**Treatment Recommended**

- |                                                |                                                                           |
|------------------------------------------------|---------------------------------------------------------------------------|
| <input type="checkbox"/> Glasses               | <input type="checkbox"/> Surgery: _____                                   |
| <input type="checkbox"/> Patches               | _____                                                                     |
| R: _____                                       | _____                                                                     |
| L: _____                                       | _____                                                                     |
| <input type="checkbox"/> Medication: _____     | <input type="checkbox"/> Referral for other medical treatment/exam: _____ |
| <input type="checkbox"/> Low Vision Evaluation | _____                                                                     |
| <input type="checkbox"/> Other: _____          | _____                                                                     |

**IMPORTANT: Check the most appropriate statement.****This Patient:**

- |                                                                     |                                                                                |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------|
| <input type="checkbox"/> Appears to have no vision.                 | <input type="checkbox"/> Appears to have a cortical vision impairment          |
| <input type="checkbox"/> Has a serious visual loss after correction | <input type="checkbox"/> Does not have a serious visual loss after correction. |

---

Print or Type Name of Licensed Ophthalmologist or Optometrist

---

Address

---

Address

---

---

---