Circle of Support, Inc.

EYE EXAMINATION

Name: _____ Address: _____

CASE HISTORY:

Ocular History: ___ Normal or Positive for: _____

Medical History ___ Normal or Positive for: _____

Drug Allergies: ___ NKDA or Allergic for: _____

FAMILY OCULAR AND MEDICAL HISTORY:

____ Amblyopia ____Strabismus ____ Glaucoma ____Diabetes ____ Other

Other Pertinent Information: _____

Refraction with cycloplegic: (Please indicate one) _____Yes _____No

	OD	OS
Unaided Acuity	20 /	20 /
Best Corrected Acuity	20 /	20 /

	NORMAL	ABNORMAL	NOT ABLE TO ASSESS
External Exam (eye and adnexa)			
Internal Exam (media, lens, fundus, etc.			
Neurological Integrity (pupils)			
Binocular Function (stereopsis)			
Accommodation and convergence			
Color Vision			

DIAGNOSIS: ___Normal ___Myopia ___ Hyperopia ___Astigmatism

___Strabismus ___ Amblyopia ___Other _____

RECOMMENDATIONS:

1. Glasses prescribed: ___ Yes ___No
2. _____
3. _____

Signed:_____ Date: _____

Optometrist/Ophthalmologist

Address: _____ Telephone: _____

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