

DOT Eye Test Template

Name: _____

Age: _____

Medical history (if applicable):

E	1	20/200
F P	2	20/100
T O Z	3	20/70
L P E D	4	20/50
P E C F D	5	20/40
E D F C Z P	6	20/30
F E L O P Z D	7	20/25
D E F P O T E C	8	20/20
L E F O D P C T	9	
F D P L T C E O	10	
F E Z O L C F T D	11	

DOT TEST

1. ●
2. ● ●
3. ● ●
4. ● ●
5. ● ● ● ●
6. ● ● ●
7. ● ● ●
8. ● ● ● ● ● ●
9. ● ● ● ●
10. ● ● ● ●

RESULTS: