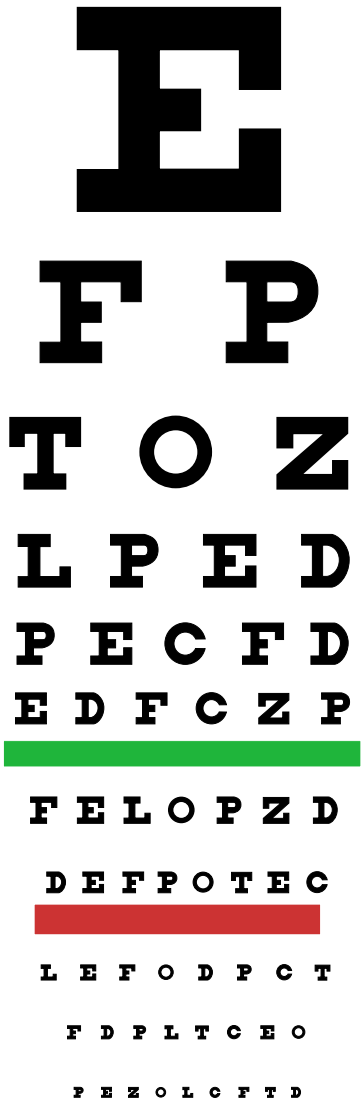
DOT Eye Test Template

Name: _____

Age: _____

Medical history (if applicable):



1	20/200
2	20/100
3	20/70
4	20/50
5	20/40
6	20/30
7	20/25
8	20/20
9	
10	
11	

DOT TEST

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

RESULTS: