

Eye Physical Examination

Patient information				
Name:	Date of birth:			
Medical record number:	Gender:			
Eye professional:	Assessment date:			
Medical history				
Pre-existing eye or vision conditions, family history, and risk factors:				
Reason for examination (include chief complaint and symptoms if applicable):				
Visual acuity				
Right eye/OD:	Left eye/OS:	Both eyes/OU:		
Notes:				
Pupil examination and relative afferent pupillary effect (RAPD)				
Light response (right):	Light response (left):	RAPD:		
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Present		
<input type="checkbox"/> Abnormal	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Not present		
Notes:				

Extraocular movement and alignment

Tests performed:

Right eye:

Left eye:

Notes:

External examination (both eyes)

Eyelids:

Lashes:

Surrounding tissue:

Conjunctiva:

Sclera:

Cornea:

Lens:

Other:

Notes:

Fundoscopic examination (right)	
Anterior chamber:	Optic nerve:
Retina:	Blood vessels:
Notes:	
Fundoscopic examination (left)	
Anterior chamber:	Optic nerve:
Retina:	Blood vessels:
Notes:	

Other tests	
Intraocular pressure (glaucoma/tonometry): <input type="checkbox"/> Assessed <input type="checkbox"/> Not assessed	Results (right):
	Results (left):
Retinoscopy/refraction: <input type="checkbox"/> Assessed <input type="checkbox"/> Not assessed	Results (right):
	Results (left):
Prescriptions and notes:	
Corneal topography: <input type="checkbox"/> Assessed <input type="checkbox"/> Not assessed	Results (right):
	Results (left):
Other:	Results (right):
	Results (left):
Other:	Results (right):
	Results (left):

Referrals and recommendations

Additional notes