Nearsighted Test

Patient Name:	
Age:	Gender:
Date:	
Symptom Assess	ment
1. Difficulty seein	g distant objects
☐ Yes	
□ No	
2. Frequent heada	aches
☐ Yes	
□ No	
3. Eyestrain & dis	comfort
☐ Yes	
□ No	
4. Squinting or pa	artially closing eyes to see
☐ Yes	
□ No	
Activity-Related Questions	
1. Experience blu	rred vision while driving
☐ Yes	
□ No	

2. Struggling to see TV or movie screens		
☐ Yes		
□ No		
3. Difficulty in outdoor games noticing distant objects		
☐ Yes		
□ No		
4. Needing to sit closer in events for clear visibility		
☐ Yes		
□ No		
Family History		
Family members diagnosed with myopia:		
☐ Yes		
□ No		
If yes, please specify their relation to the patient:		
Visual Acuity		
Uncorrected Visual Acuity		
Right Eye:		
Left Eye:		
Corrected Visual Acuity (if applicable)		
Right Eye:		
Left Eye:		

Refraction Assessment
Right Eye
Sphere:
Cylinder:
Axis:
Left Eye
Sphere:
Cylinder:
Axis:
Diagnosis and Plan
Diagnosis:
Diopter measurement (if myopia is confirmed):
Prescription details for corrective glass or lenses (if myopia is confirmed):
Recommended next steps: