Nearsighted Test

Patient Name:
Age: Gender:
Date:
Symptom Assessment
1. Difficulty seeing distant objects
☐ Yes
□ No
2. Frequent headaches
□ Yes
□ No
3. Eyestrain & discomfort
□ Yes
□ No
4. Squinting or partially closing eyes to see
□ Yes
□ No
Activity-Related Questions
1. Experience blurred 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: