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:
Follow-up appointment (if needed):