

Neuro-Ophthalmological Examination Record

Patient Information

- Name: _____
- Date of Birth: _____
- Date of Examination: _____
- Referring Physician: _____

Examination

Visual Acuity

- Right Eye: _____
- Left Eye: _____
- Corrected/Un-Corrected: _____

Visual Fields

- Right Eye:
 - Description of Visual Field: _____
- Left Eye:
 - Description of Visual Field: _____

Color Vision

- Test Used: _____
- Results:
 - Right Eye: _____
 - Left Eye: _____

Stereopsis

- Test Used: _____
- Results: _____

External Examination

- Eyes and Lids:
 - Observations: _____

Pupillary Examination

- Right Pupil Size: _____

- Left Pupil Size: _____
- Reactivity to Light: _____
- Near Response: _____

Ophthalmoscopic Examination

- Optic Disc (Right Eye): _____
- Optic Disc (Left Eye): _____
- Retinal Examination:
 - Right Eye: _____
 - Left Eye: _____

Eye Movements



- Extraocular Movements:
 - Right Eye: _____
 - Left Eye: _____
- Nystagmus (if present):
 - Direction: _____
 - Observed in (Right/Left/Both Eyes): _____

Overall Assessment and Notes

- Diagnosis (if any): _____
- Additional Observations:

- Recommended Follow-up/Treatment:

Signatures

- Examiner's Signature:  _____
- Date: _____
- Patient's/Parent's/Guardian's Signature (if applicable):  _____
- Date: _____