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: _____**