

Neurological Eye Exam

Patient Information:

Name:

Age:

Date of Birth:

Sex:

Medical History:

Any history of neurological conditions (e.g., multiple sclerosis, stroke)?:

Any history of eye-related issues (e.g., glaucoma, macular degeneration)?:

Chief Complaint:

Reason for the Neurological Eye Exam:

Visual Acuity:

Distance Vision:

Near Vision:

Visual Fields:

Confrontation Test:

Automated Perimetry:

Pupillary Exam:

Pupillary Size and Reactivity:

Swinging Flashlight Test:

Ocular Motility:

Extraocular Movements:

Nystagmus Testing:

Optic Nerve Examination:

Disc Appearance:

Optical Coherence Tomography (OCT):

Additional Tests (if indicated):

Color Vision Testing (Ishihara, Farnsworth D-15):

Contrast Sensitivity Testing:

Summary and Recommendations:

Follow-up Plan: