Eye Exam Form Template

Date:

Patient's Name:

Address:

Email:

Phone Number:

Patient's Signature:

Optometrist/Physician Name:

Case History

	Normal	Other
Ocular History	☐	
Medical history	☐	
Drug Allergies	☐	

Examination

Unaided Visual Acuity (20/) - Distance / Right	Unaided Visual Acuity (20/) - Distance / Left
Unaided Visual Acuity (20/) - Distance / Both	**Unaided Visual Acuity (20/) - Near / Both**
Best Corrected Visual Acuity (20/) - Distance / Right	**Best Corrected Visual Acuity (20/) - Distance / Left**

Best Corrected Visual Acuity (20/) - Distance / Both	Best Corrected Visual Acuity (20/) - Near / Both

	Normal	Abnormal	Other
Dilation	☐	☐	
Stereopsis	☐	☐	
Peripheral Vision	☐	☐	
Neurological Integrity (Pupils)	☐	☐	
Retina	☐	☐	
Various Parts of the Eye (Eyelid, Iris, Cornea, Sclera)	☐	☐	
Color Vision	☐	☐	
IOP or Tonometry (Glaucoma)	☐	☐	

Recommendations

Corrective Lenses
☐ Yes ☐ No
Preferential seating recommended
☐ Yes ☐ No

Recommend re-examination

- ☐ 3 months
- ☐ 6 months
- ☐ 12 months
- ☐ Other