Trochlear Nerve (Cranial Nerve IV) Test Results Document

Patient Information:

- Name: _____
- Date of Birth: _____
- Date of Examination: _____
- Examiner: _____

Medical History:

- Relevant Past Medical History:
- Current Medications:
- Previous Eye or Neurological Conditions:

Visual Inspection:

- Eyelid Position and Function: _____
- Eye Alignment and Symmetry: _____

Pupil Response Test:

- Direct Light Reflex (Right Eye): _____ (Normal/Abnormal)
- Consensual Light Reflex (Right Eye): _____ (Normal/Abnormal)
- Direct Light Reflex (Left Eye): _____ (Normal/Abnormal)
- Consensual Light Reflex (Left Eye): _____ (Normal/Abnormal)
- Notes:

Eye Movement Test:

- Right Eye Movements: Upward / Downward / Left / Right: _____ (Normal/Restricted)
- Left Eye Movements: Upward / Downward / Left / Right: _____ (Normal/Restricted)
- Superior Oblique Muscle Function (Downward & Outward Movement):
  - Right Eye: _____ (Normal/Impaired)
  - Left Eye: _____ (Normal/Impaired)
- Notes:

Double Vision Test:

- [ ] Presence of Diplopia

- Description of Diplopia (if present): _____

Cover Test:

- Findings (Right Eye):

- Findings (Left Eye):

- Notes:

Head Tilt Test:

- Head Tilt to the Right: Effect on Eye Position / Vision:

- Head Tilt to the Left: Effect on Eye Position / Vision:

- Notes:

Fundoscopy:

- Optic Disc Appearance:

- Vascular Changes:

- Other Observations:

Additional Notes:

Impression / Diagnosis:

Recommendations / Referrals:

- Further Investigations:

- Specialist Referral (if needed):

- Follow-Up:

Examiner's Signature: _____ Date: _____