


Vision Screening Test

Patient Information	
Full Name:	
Date of Birth:	
Address:	
Phone Number:	
Email Address:	
Medical History & Related Questions	
Have you had any eye surgeries?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear glasses or contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any family history of eye diseases?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you experienced any of the following symptoms? (Check all that apply)	<input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision <input type="checkbox"/> Eye pain <input type="checkbox"/> Flashes or floaters
Tests	
Visual Acuity (Right Eye):	
Visual Acuity (Left Eye):	
Color Vision Test:	<input type="checkbox"/> Pass <input type="checkbox"/> Fail

Depth Perception Test:	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
Findings (with basis of findings)	
Visual Acuity Findings:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (Specify: _____)
Color Vision Findings:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (Specify: _____)
Depth Perception Findings:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (Specify: _____)
Interpretation	
Overall Vision Status:	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Recommendations:	
Overall Interpretation (if possible)	
Summary:	
Doctor's Verification	
Signature:	
Name:	
Date:	