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?	☐ Yes ☐ No
Do you wear glasses or contact lenses?	☐ Yes ☐ No
Any family history of eye diseases?	☐ Yes ☐ No
Have you experienced any of the following symptoms? (Check all that apply)	☐ Blurred vision ☐ Double vision ☐ Eye pain ☐ Flashes or floaters
Tests	
Visual Acuity (Right Eye):	
Visual Acuity (Left Eye):	
Color Vision Test:	☐ Pass ☐ Fail

Depth Perception Test:	☐ Pass ☐ Fail
Findings (with basis of findings)	
Visual Acuity Findings:	☐ Normal ☐ Abnormal (Specify: _____)
Color Vision Findings:	☐ Normal ☐ Abnormal (Specify: _____)
Depth Perception Findings:	☐ Normal ☐ Abnormal (Specify: _____)
Interpretation	
Overall Vision Status:	☐ Normal ☐ Abnormal
Recommendations:	
Overall Interpretation (if possible)	
Summary:	
Doctor's Verification	
Signature:	
Name:	
Date:	