NAME ______________________ DATE (Day / Month / Year) ____/____/____

DATE OF BIRTH (Day / Month / Year) ___/_____/_____ AGE _______ SEX Male [ ] Female [ ]

OCCUPATION ______________________

ADDRESS ______________________ PHONE ____________

CITY ______________________ AREA: Urban [ ] Rural [ ]

I. SUBJECTIVE

COMPLAINT Far Vision [ ] Near Vision [ ] ______________________

Hypertension [ ] Diabetes [ ] Allergy [ ] Other ______________________

VISUAL ACUITY

	No Lenses			With Lenses	
	Far	Pinhole	Near	Far	Near
R					
L					

OLD PRESCRIPTION

	Sphere	Cylinder	Axis	Add
OD				
OS				

II. OBJECTIVE

EXTERNALS Right [ ] Left [ ] ______________________

PUPILS Right [ ] Left [ ] ______________________

OPHTHALMOSCOPY

R ______________________

L ______________________

A = RETINOMAX B = RETINOSCOPY

A	R			
	L			
B	R			
	L			

TONOMETRY

R	
L	

III. ASSESSMENT

	R	L		R	L		R	L		R	L
Hypermetropia	[ ]	[ ]	Strabismus	[ ]	[ ]	Keratitis	[ ]	[ ]	Hypertensive Retinopathy	[ ]	[ ]
Myopia	[ ]	[ ]	Acute Conjunctivitis	[ ]	[ ]	Pterygion	[ ]	[ ]	Choroidal Scar	[ ]	[ ]
Astigmatism	[ ]	[ ]	Chronic Conjunctivitis	[ ]	[ ]	Aphakia	[ ]	[ ]	Macular Degeneration	[ ]	[ ]
Presbyopia	[ ]		Corneal Ulcer	[ ]	[ ]	Diabetic Retinophathy	[ ]	[ ]			
Amblyopia	[ ]	[ ]	Corneal Opacity	[ ]	[ ]						

Cataract - Left: Mild [ ] Moderate [ ] Severe [ ]
Right: Mild [ ] Moderate [ ] Severe [ ]

IV. PLAN

FINAL PRESCRIPTION

	Sphere	Cylinder	Axis	Add
OD				
OS				

PRESCRIPTIVE ALTERNATIVE

	Sphere	Cylinder	Axis	Add
OD				
OS				

Number of Glasses _____ Near [ ] Far[ ] Bifocals [ ] Plano Sun [ ]

EYE GLASS BANK (What's available in inventory)

	Sphere	Cylinder	Axis	Add
OD				
OS				

MEDICATION:

SURGERY RECOMMENDED [ ]

NOTES:

Examiner:___________