

Report of Ocular/ Visual Examination

TO	
EXAMINATION DATE	day / month / year
PATIENT'S NAME	First name / Last name
DATE OF BIRTH	day / month / year

VISUAL ACUITY				
		Unaided (No Glasses)	Present Glasses	Best Possible Acuity
Distance	Right Eye	20/	20/	20/
	Left Eye	20/	20/	20/
	Both Eyes	20/	20/	20/
Near	Right Eye	20/	20/	20/
	Left Eye	20/	20/	20/
	Both Eyes	20/	20/	20/

REFRACTIVE STATUS	
<input type="checkbox"/> Myopia (Near-sighted) <input type="checkbox"/> Hyperopia (Far-sighted) <input type="checkbox"/> Astigmatism <input type="checkbox"/> Presbyopia	

COLOUR VISION	
<input type="checkbox"/> Pass <input type="checkbox"/> Fail	Test:

PERIPHERAL VISUAL FIELDS	
<input type="checkbox"/> Full by Confrontation	<input type="checkbox"/> Restricted as Follows:

OCULAR HEALTH STATUS	
<input type="checkbox"/> No Abnormality Detected	<input type="checkbox"/> As Follows:

RECOMMENDATIONS	
<input type="checkbox"/> No Treatment Required	
<input type="checkbox"/> Eyeglasses Required for:	<input type="checkbox"/> Distance Viewing Only <input type="checkbox"/> Reading and Near Work Only <input type="checkbox"/> Full Time Wear
<input type="checkbox"/> Referral To:	
<input type="checkbox"/> Additional Comments/Recommendations:	

NEXT EYE EXAMINATION RECOMMEND IN	
Signed	Date