Vision Screening Test

PATIENT INFORMATION

Full Name: _____ **Date of Birth:** _____ dd / mm / yyyy

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:** _____ dd / mm / yyyy