Eyes and Vision

Name: ____ Date: ____________

Age: ____________ Gender: _______________

History

Review of History Related to Eyes and Vision:

YES/NO			**If YES, provide details:**
Date of last eye exam: _____________________			
Vision			
☐	☐	Blurry vision	______________________
☐	☐	Change in vision	______________________
☐	☐	Double vision	______________________
☐	☐	Loss of vision	______________________
☐	☐	Floaters within visual field	______________________
☐	☐	Straining to see	______________________
☐	☐	Headaches related to vision	______________________
☐	☐	Glasses or contacts	______________________
Eyes			
☐	☐	History of eye disease	______________________
☐	☐	Crusting or lesions on eyelids	______________________
☐	☐	Redness of eyes	______________________
☐	☐	Eye pain	______________________
☐	☐	Drainage from around eyes	______________________
☐	☐	Breathing difficulties	______________________
☐	☐	Cough or cold	______________________
☐	☐	Asthma or respiratory problems	______________________
☐	☐	Allergies	______________________
☐	☐	Other	______________________

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Family history of vision or eye problems:

____

____

Medical history relevant to eyes/vision (example: diabetes mellitus, hypertension etc.):

____

____

____

Review of history related to the current visit:

Focused symptom analysis of current problem:

Reason for visit: ____

____

Character: ____

Onset: ____

Duration: ____

Location: ____

Severity: ____

Associated problems: ____

Efforts to treat: ____

Current medications: ____

____

____

Allergies: ____

____

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Physical Assessment

Vision:

General evaluation of vision (glasses, contact lenses, corrective surgery):

____

____

Distant vision (Snellen chart or E Card)

Right eye uncorrected	____________	Right eye corrected	_____________
Left eye uncorrected	____________	Left eye corrected	_____________
Both eyes uncorrected	____________	Both eyes corrected	_____________

Near vision (Rosenbaum or near vision card)

Right eye uncorrected	____________	Right eye corrected	_____________
Left eye uncorrected	____________	Left eye corrected	_____________
Both eyes uncorrected	____________	Both eyes corrected	_____________

Eyes

General characteristics — eyes (position, alignment, size):

____

____

Inspect and palpate.

Eyebrows (infestation, infection): ____

Eyelids (opening, ptosis, tremors, redness, swelling, flaking): ____________________________

____

Eye orbit (lacrimal gland, lacrimal ducts, firmness, pain or discomfort): ______________________

____

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Conjunctiva (color, discharge): ____

____

External eyes (corneal clarity, pupil size, shape, reactivity): ______________________________

____

Eye muscles and movement:

Corneal light reflex: ____

Cover/uncover test: ____

Six cardinal fields of gaze: ____

Ophthalmoscopic Exam

	Right Eye	Left Eye
Lens clarity		
Red reflex		
Retina (color, surface characteristics)		
Disc characteristics		
Macula characteristics		

Analysis:

____

____

____

____

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