

DIVISION OF ADULT LEARNING AND REHABILITATION

EYE EXAMINATION REPORT

Applicant's Name: _____ DOB _____ Sex _____

Address: _____
(Street and Number) (City or Town) (State) (Zip Code)

Telephone # _____ Social Security # _____

HISTORY:

1. Is there a visual impairment? _____ If yes, which eye: right _____ left _____ both _____
2. Date of onset of the impairment or approximate duration: _____ Unknown: _____
3. Is there a family history of similar eye condition? _____ If yes, please state relationship(s) _____

PHYSICAL EXAMINATION:

Visual Acuity: (With Best Correction)
Distance (20 feet) Near (14 inches)

Right Eye _____
Left Eye _____

Visual Fields:
Is there any limitation in the field of vision?

Right eye _____ Left eye _____
If yes, attach copy of field charts.

DIAGNOSIS: Primary Secondary

Right Eye: _____

Left Eye: _____

Cause if Known: Right Eye: _____
 Left Eye: _____

Refraction findings if pertinent : Right Eye: _____
 Left Eye: _____

PROGNOSIS AND RECOMMENDATIONS:

1. Is the eye condition causing visual impairment:
Stable _____ Slowly progressive _____ Rapidly progressive _____ Rate of progression unknown _____
2. Should any physical activities be limited because of eye condition? _____
3. Is medical or surgical treatment indicated? _____ If yes, please explain _____
4. Would you recommend a low vision evaluation? _____
5. Any other recommendations or comments? _____

Date of Examination: _____

Signature of Ophthalmologist/Optomtrist

Please Print Name: _____

Address of Dr. _____

Please return to:

Services for Blind and Visually Impaired, 21 So. Fruit St., Suite 20, Concord, NH 03301
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