First Name	**Last Name**	**HAS ID** ___________________________

Date	**O Male O Female**	**DoB**	**Age (years) O Not sure**
Event	Location	O Athlete O Unified partner	Sport
Delegation		SO Program	
Cell phone # (optional)		**Number is O Athlete's O Parent's / Guardian 's**	

History

When was your last eye exam?
- O Less than 1 year
- O 1-3 years
- O More than 3 years
- O Never
- O Unknown

Do you experience any of the following
- ☐ Difficulty seeing: ☐ Far ☐ Near
- ☐ Headaches
- ☐ Sensitivity to light
- ☐ Double vision: ☐ Far ☐ Near

Do you wear corrective lenses (glasses or contacts)? O No O Yes

☐ Standard Rx *☐ Sports Rx* *☐ Contact lenses*

☐ Full time ☐ Near only ☐ Far only O Soft O Hard

Please check what is worn during screening: O Without Glasses O With Glasses O With contact lenses

Current prescription

	Sphere	Cylinder	Axis	Add
Right Eye				
Left Eye				

Visual Acuity FAR **Right Eye** 20 /___ ☐ *Unable to test* **Left Eye** 20 /___ ☐ *Unable to test*

O Lea	O Walk up	O Light projection/Light perception	O Walk up	O Light projection/Light perception
		O No light perception		O No light perception
	Other:		Other:	

NEAR **Both Eyes** 20 /___ ☐ *Unable to test*

O Lea	O Light projection/Light perception	O No light perception	Other:

Cover Test FAR ☐ *Unable to test*

☐ orthophoria O PHORIA range 02-99 ___ O TROPE range 02-99 ___

O eso O exo O hyper O eso O exo O hyper O hyper/eso O hyper/exo

O Latent Nystagmus *O Constant O Intermittent*

NEAR ☐ *Unable to test*

☐ orthophoria O PHORIA range 02-99 ___ O TROPE range 02-99 ___

O eso O exo O hyper O eso O exo O hyper O hyper/eso O hyper/exo

O Constant O Intermittent

Color Vision ☐ *Unable to test* CVME: Trial 1_ /9 If less than 8/9 Trial 2_ /9 **Stereopsis** ☐*Unable to test* __ / 6 ☐RDE ☐PASS

Color√: __/14 symbols (does not include demonstration card)

Autorefraction

		Sphere	Cylinder	Axis
☐ Unable to test	Right Eye			
☐ Unable to test	Left Eye			

Eye Health External **Right Eye** ☐ *Unable to test* **Left Eye** ☐ *Unable to test*

O Nystagmus

Right Eye: ☐Normal ☐Lid anomaly ☐Pterigium/pinguecula ☐Blepharitis ☐ Corneal anomaly ☐Conjunctivitis ☐ Iris anomaly ☐Ptosis

Left Eye: ☐Normal ☐Lid anomaly ☐Pterigium/pinguecula ☐Blepharitis ☐ Corneal anomaly ☐Conjunctivitis ☐ Iris anomaly ☐Ptosis

Abnormality:

Internal **Right Eye** ☐ *Unable to test* **Left Eye** ☐ *Unable to test*

Right Eye: ☐Normal ☐ Cataracts ☐ Retinal anomaly ☐ Coloboma ☐ Optic Nerve anomaly ☐ Glaucoma suspect

Left Eye: ☐Normal ☐ Cataracts ☐ Retinal anomaly ☐ Coloboma ☐ Optic Nerve anomaly ☐ Glaucoma suspect

Abnormality:

IOP **Right Eye** _____ **Left Eye** _____ **Pupils** O Normal O Abnormal: _______________

☐ *Unable to test* O Icare O Noncontact ☐ *Unable to test*

	Right Eye	**Left Eye**	**OU**	Add
Retinoscopy	20/ ___	20/ ___	20/ ___	
Refraction	20/ ___	20/ ___	20/ ___	20/ ___

Recommendations:

O **No new Rx** O No glasses recommended O No change in glasses recommended ☐ **Sunglasses (plano)**

O **New Rx** ☐ **Full time Rx** ☐ **Distance only** ☐ **Close work only**

PD __/__

	Sphere	Cylinder	Axis	VA Distance	Distance OU	VA Near (OU)	ADD
Right eye				20 / ____	20 / ____	20 / ____	
Left eye				20 / ____			

☐ **Sports goggles:** O Plano O Rx

Right eye				20 / ____
Left eye				20 / ____

Referral to: ☐ Optometrist ☐ Ophthalmologist ☐ Primary care physician ☐ Neurologist ☐ Other: ________________

Urgent Referral 0 Yes 0 No **Additional comments:**

Opening Eyes