## Opening Eyes

### 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 wear corrective lenses (glasses or contacts)?**
  - Standard Rx
  - Sports Rx
  - Contact lenses

- **Do you experience any of the following?**
  - O Difficulty seeing
  - O Far
  - O Near
  - O Headaches
  - O Sensitivity to light
  - O Double vision
  - O Far
  - O Near

- **Check what is worn during screening:**
  - O Without Glasses
  - O With Glasses
  - O With contact lenses

### Visual Acuity

<table>
<thead>
<tr>
<th>FAR</th>
<th>Right Eye</th>
<th>20/___</th>
<th>O Unlable to test</th>
<th>Left Eye</th>
<th>20/___</th>
<th>O Unlable to test</th>
</tr>
</thead>
<tbody>
<tr>
<td>O Lea</td>
<td>O Walk up</td>
<td>O Light projection/Light perception</td>
<td>O Walk up</td>
<td>O Light projection/Light perception</td>
<td></td>
<td></td>
</tr>
<tr>
<td>O No light perception</td>
<td>O No light perception</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NEAR</th>
<th>Both Eyes</th>
<th>20/___</th>
<th>O Unlable to test</th>
<th>O No light perception</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>O Lea</td>
<td>O Light projection/Light perception</td>
<td>O No light perception</td>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Cover Test

- **FAR**
  - O orthophoria
  - O PHORIA
  - O range 02-99
  - O eso
  - O eso
  - O hyper

- **Left Eye**
  - O TROPE
  - O range 02-99
  - O eso
  - O eso
  - O hyper

- **Near**
  - O orthophoria
  - O PHORIA
  - O range 02-99
  - O eso
  - O eso
  - O hyper

- **TROPE**
  - O range 02-99
  - O eso
  - O eso
  - O hyper

### Color Vision

- **CAM VE: Trial 1 /9**
- **If less than 8/9**
- **Trial 2 /9**
- **Stereopsis**
- **Unable to test**

### Autorefration

- **Sphere**
- **Cylinder**
- **Axis**
- **Add**

### Eye Health

- **External**
  - O Right Eye
  - O Latent Nystagmus
  - O Normal
  - O Lid anomaly
  - O Pterygium/pinguecula
  - O Blepharitis
  - O Corneal anomaly
  - O Conjunctivitis
  - O Iris anomaly
  - O Ptosis

### IOP

- **Right Eye**
  - O Icare
  - O Noncontact
  - O Unlable to test

### Recommendations:

- **No new Rx**
- **New Rx**
  - O Full time Rx
  - O Distance only
  - O Close work only

### Referral to:

- O Optometrist
- O Ophthalmologist
- O Primary care physician
- O Neurologist

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**2015**

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**First Name**

**Last Name**

**HAS ID ______________________**

**Event**

**Location**

**DoB**

**Age (years)**

**O Not sure**

**Cell phone # (optional)**

**Number is O Athlete’s O Parent’s / Guardian’s**

**Date**

**O Male**

**O Female**

**Delegation**

**SO Program**

**Special Olympics Lions Clubs International Opening Eyes**

**Opening Eyes**

**2015**