

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?

- Less than 1 year
- 1-3 years
- More than 3 years
- Never
- 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)?

- Standard Rx Full time Near only Far only
- Sports Rx
- Contact lenses Soft Hard

Please check what is worn during screening:

- Without Glasses With Glasses With contact lenses

Current prescription

Right Eye				
Left Eye				

Visual Acuity

FAR **Right Eye** 20 / ____ Unable to test **Left Eye** 20 / ____ Unable to test

<input type="checkbox"/> Lea	<input type="checkbox"/> Walk up	<input type="checkbox"/> Light projection/Light perception	<input type="checkbox"/> Walk up	<input type="checkbox"/> Light projection/Light perception
		<input type="checkbox"/> No light perception		<input type="checkbox"/> No light perception
Other:		Other:		

NEAR **Both Eyes** 20 / ____ Unable to test

<input type="checkbox"/> Lea	<input type="checkbox"/> Light projection/Light perception	<input type="checkbox"/> No light perception	Other:
------------------------------	--	--	--------

Cover Test

- FAR orthophoria PHORIA range 02-99 ____ TROPE range 02-99 ____
- Unable to test
- eso exo hyper eso exo hyper hyper/eso hyper/exo
- Constant Intermittent

O Latent Nystagmus

- NEAR orthophoria PHORIA range 02-99 ____ TROPE range 02-99 ____
- Unable to test
- eso exo hyper eso exo hyper hyper/eso hyper/exo
- Constant 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
ColorV: ____/14 symbols (does not include demonstration card)

Autorefraction

<input type="checkbox"/> Unable to test		Sphere	Cylinder	Axis
<input type="checkbox"/> Unable to test	Right Eye			
	Left Eye			

Eye Health External

- | | |
|--|--|
| Right Eye <input type="checkbox"/> Unable to test | Left Eye <input type="checkbox"/> Unable to test |
| <input type="checkbox"/> Normal <input type="checkbox"/> Lid anomaly <input type="checkbox"/> Pterigium/pinguecula | <input type="checkbox"/> Normal <input type="checkbox"/> Lid anomaly <input type="checkbox"/> Pterigium/pinguecula |
| <input type="checkbox"/> Blepharitis <input type="checkbox"/> Corneal anomaly | <input type="checkbox"/> Blepharitis <input type="checkbox"/> Corneal anomaly |
| <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Iris anomaly | <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Iris anomaly |
| <input type="checkbox"/> Ptosis | <input type="checkbox"/> Ptosis |

O Nystagmus

Abnormality: _____

Internal

- | | |
|---|---|
| Right Eye <input type="checkbox"/> Unable to test | Left Eye <input type="checkbox"/> Unable to test |
| <input type="checkbox"/> Normal <input type="checkbox"/> Cataracts <input type="checkbox"/> Retinal anomaly | <input type="checkbox"/> Normal <input type="checkbox"/> Cataracts <input type="checkbox"/> Retinal anomaly |
| <input type="checkbox"/> Coloboma <input type="checkbox"/> Optic Nerve anomaly | <input type="checkbox"/> Coloboma <input type="checkbox"/> Optic Nerve anomaly |
| <input type="checkbox"/> Glaucoma suspect | <input type="checkbox"/> Glaucoma suspect |

Abnormality: _____

IOP

Right Eye ____ **Left Eye** ____ **Pupils** Normal Abnormal: _____
 Unable to test Icare Noncontact Unable to test

	Right Eye	Left Eye	OU	Add
Retinoscopy	20 / ____	20 / ____	20 / ____	
Refraction	20 / ____	20 / ____	20 / ____	20 / ____

Recommendations:

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

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: Plano Rx

Right eye			20 / ____
Left eye			20 / ____

Referral to: Optometrist Ophthalmologist Primary care physician Neurologist Other: _____

Urgent Referral Yes No

Additional comments: _____