Homes For Kids Inc.
Child and Family Solutions
Opening Doors for Children & Families Since 1990

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Optical Exam Form

Name:_____

Address:_____

Date of Birth:_____

Date of Exam:_____

Ocular History: Normal ___ or Positive for:_____
Medical History: Normal ___ or Positive for:_____
Drug Allergies: Normal ___ or Positive for: _____
Family Ocular and Medical History: ___ Amblyopia ___ Strabismus ___ Glaucoma ___ Diabetes
Other:_____

Other Pertinent Information:_____

Refraction with cycloplegic? (Please Indicate one) ___ Yes ___ No

	OD	OS
Unaided Acuity	20 / _____	20 / _____
Best Corrected Acuity	20 / _____	20 / _____

	Normal	Abnormal	Not able to Assess
External Exam (eye adnexa)	____	____	____
Internal Exam (media, lens,fundus,etc.)	____	____	____
Neurological Integrity (pupils)	____	____	____
Binocular Function (stereopsis)	____	____	____
Accommodation and convergence	____	____	____
Color Vision	____	____	____

Diagnosis: ___ Normal ___Myopia ___Hyperopia ___ Astigmatism ___ Strabismus ___ Amblyopia
Other:_____

Recommendations: 1. Glasses prescribed: ____ Yes ____ No

Age Appropriate and suggested anticipatory guidance (health assessments):
__ Educate (parents/patients) about eye/vision disorder and needed vision care
__ Counsel (parents/patients) regarding eye safety
__ Stress importance of early, preventative eye care
__Recommend re-examination, as appropriate

Signed: _____ Date:_____
Optometrist /Ophthalmologist

Address: _____ Telephone: ( )_____