N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND

REPORT OF EYE EXAMINATION

Check One

☐ SAB ☐ Rehab. Appl./ Client ☐ Register f/t Blind ☐ AB- MA only ☐ M/ECP Client ☐ Other Prog. Recip.

NAME _____ _____ _____ _____ _____
(Last) (First) (MI) (Maiden Name) TELEPHONE

DATE OF BIRTH _____ SEX _____ RACE _____ If child, parent's name _____

ADDRESS _____ _____ _____ _____
(Street) (City) (State) (Zip code)

COUNTY _____

PATIENT COMPLAINT _____

BRIEF MEDICAL HISTORY _____

_____

PRIMARY DIAGNOSIS _____

SECONDARY DIAGNOSIS _____

Description of eyes, including fundi: _____

_____

CENTRAL VISUAL ACUITY: Use Snellen Designation where possible; where not, record C. F. (Count Fingers), H.M. (Hand Movements), L.P. (Light Perception) or N.L.P. (No Light Perception).

VISION:

	Without Glasses	With Old Glasses
R	_____	_____
L	_____	_____

Refraction (Cycloplegic) (Manifest)

Check type:	Sphere	Cylinder	Axis
R			
L			

Vision with Best Correction

R _____

L _____

Prescription

	Sphere	Cylinder	Axis
R			
L			
R			
L			

INTRAOCULAR PRESSURE: Right Eye _____ Left Eye _____ by _____ (Method)

Is there any limitation in the field of vision? No ☐ Yes ☐

What is the widest diameter in degrees of remaining Visual Field? Right _____ Left _____

ETIOLOGY: Disease ☐ Injury ☐ Poisoning ☐ Heredity ☐ Prenatal Influence ☐ ONSET DATE _____

PROGNOSIS: Is patient's visual impairment considered to be: Stable ☐ Deteriorating ☐ Capable of Improvemt ☐ Uncertain ☐

REMARKS: _____

RECOMMENDATIONS: _____

_____

_____

_____

Date of Examination _____ Signature of Examiner _____ M.D. ☐ O.D. ☐

When should patient be re-examined? _____ Address _____

Data below filled out by State Supervising Ophthalmologist certifying legal blindness

Approved _____ Not Approved _____

Recommend re-examination _____ Specify recommended eye treatment _____

Date _____ Signature _____
State Supervising Ophthalmologist

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