

Ardmore Enterprises, Inc.

EYE/VISION EXAMINATION

Name: _____ Appt. date and time: _____

Appointment location and telephone number: _____

	Normal	Abnormal	Not Examined	Findings
Conjunctive				
Cornea				
Sclera				
Pupils				
Lens				
Fundi				
Acuity				
Movement				

Distance vision: Without glasses: Right – 20/____ Left – 20/____

 With glasses: Right – 20/____ Left – 20/____

Wears glasses: () No () Yes

Test for glaucoma results: _____

Recommendations: _____

Signature of eye care professional

Printed name of eye care professional