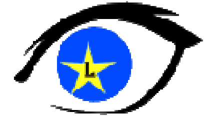
LIONS VISION CLINIC
EYE EXAMINATION REPORT



District: ______________________ CLINIC LOCATION:___________________________________

Date: __________ Name: _______________________________________ School:_________________

DOB: ______/______/_________ Age:______ Sex: M F

Address: _______________________________ City:__________________ State: TX Zip:_________

Home Phone #: __________________________ Parent's Work #:_______________________

DO NOT WRITE BELOW THIS LINE

Drops Timings #1: ____:____ #2:____:____ #3:____:____

ACUITY

			V/A
NO RX	OD		
	OS		
PRESENT RX	OD		
	OS		
RETINOSCOPY	OD		
	OS		
REFRACTION	OD		
	OS		

MUSCLE FUNCTION

Normal

Abnormal: ____________

EXTERNAL

Normal

Abnormal: ____________

FUNDI

Normal

Abnormal: ____________

DIAGNOSIS:____

TREATMENT GLASSES (FULL TIME NEAR DISTANCE)

_____________________________________ DOCTOR'S NAME (print)

_____________________________________ ADDRESS

_____________________________________ DOCTOR'S SIGNATURE

_____________________________________ PHONE

FRAME INFORMATION

SKU: _______________________ PD: R _____________ OC: ☐ CHECK BOX

COLOR/SIZE: _________________________ L _____________