STATE OF NH SERVICES FOR BLIND AND VISUALLY IMPAIRED
EYE EXAMINATION REPORT

Applicant's Name: _____ **DOB** _____ **Sex** _____

Address: _____
(Street and Number) (City or Town) (State) (Zip Code)

Telephone # _____ **Social Security #** _____

HISTORY:

1. Is there a visual impairment? _____ If yes, which eye: Right _____ Left _____ Both _____
2. Date of onset of the impairment or approximate duration: _____ Unknown: _____
3. Is there a family history of similar eye condition? _____ If yes, please state relationship(s) _____

PHYSICAL EXAMINATION:

Visual Acuity: (With Best Correction)

	(20 feet) Distance	(14 inches) Near
Right Eye	_____	_____
Left Eye	_____	_____

Visual Fields: **PLEASE NOTE**
Is there any limitation in the field of vision?
******If yes, please attach copy of field charts.******
Right Eye _____ Left Eye _____

DIAGNOSIS:

Primary **Secondary**

Right Eye: _____

Left Eye: _____

Cause if Known: Right Eye: _____

Left Eye: _____

Refraction findings if pertinent: Right Eye: _____

Left Eye: _____

PROGNOSIS AND RECOMMENDATION:

1. Is the eye condition causing visual impairment:

   Stable _____ Slowly progressive _____ Rapidly progressive _____ Rate of progression unknown _____

2. Should any physical activities be limited because of eye condition?: _____
3. Is medical or surgical treatment indicated?: _____ If yes, explain _____
4. Would you recommend low vision aid evaluation? _____
5. Any other recommendations or comments? _____

Date of Examination: _____ _____
Signature of Ophthalmologist/Optometrist

Please Print Name: _____

and Address of Dr. _____

_____

Telephone Number: _____

FAX Number: _____

Please return to:
Services for Blind and Visually Impaired, 21 So. Fruit St., Suite 20, Concord, NH 03301 (FAX: 603-271-3816)