COLLEGE OF SOUTHERN IDAHO

Health Sciences and Human Services

Dental Hygiene Eye Examination Form

Date:

IDENTIFYING INFORMATION				
Student Name:				
Birth Date:				
Address:				
City, State, Zip:				
Phone:				
To Be Completed By Examining Doctor (Return form to the Student)				
Case History			Date of Exam:	
Ocular History:	☐ Normal	or Positive for:		
Medical History:	☐ Normal	or Positive for:		
Drug Allergies:	☐ NKDA	or Allergic to:		
Other Information:				
Examination				
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	
Comments:				
External Exam (eye and adnexa)	☐	☐	☐	
Internal Exam (media, lens, fundus, ect.)	☐	☐	☐	
Neurological Integrity (pupils)	☐	☐	☐	
Binocular Function (stereopsis)	☐	☐	☐	
Accommodation and Vergence	☐	☐	☐	
Color Vision	☐	☐	☐	
IOP (glaucoma)	☐	☐	☐	
Oculomotor Assessment	☐	☐	☐	
Other:	☐	☐	☐	
Diagnosis				
☐ Normal	☐ Myopia	☐ Hyperopia	☐ Astigmatism	☐ Strabismus ☐ Amblyopia
Other:				
Recommendations				
Corrective Lenses:	☐ No	☐ Yes, glasses should be worn for:	☐ Constant Wear	
☐ Near Vision	☐ Far Vision	☐ May Be Removed for Physical Education		
Recommended re-examination:	☐ 3 months	☐ 6 months	☐ 12 months	☐ Other:
Comments:				
Print Name:				
Optometrist or Physician Who Provides Eye Examinations				
Address:				
City, State, Zip:				
Signature:		Phone:		
Optometrist or Physician Who Provides Eye Examinations				