U.S. Department of Transportation - Federal Aviation Administration

REPORT OF EYE EVALUATION

1. DATE		
2A. NAME OF AIRMAN	2B. DATE OF BIRTH	2C. SEX

3. ADDRESS OF AIRMAN

4. HISTORY - Record pertinent history, past and present, concerning general health and visual problems.

5. HETEROPHORIA - Record phorias, in prism diopters, with and without best lens correction in place

	(1) AT 20 FEET	(2) AT 18 INCHES
A. WITHOUT CORRECTION	EXO. ESO. HYPER.	EXO. ESO HYPER.
B. WITH CORRECTION (if any)	EXO. ESO. HYPER.	EXO. ESO. HYPER.

6. FUSION - Estimate fusion ability and state methods used in examination. *(Red lens, etc.)*

7. PUPILS - Statement of relative size and reaction of the pupils to accomodation and light, direct and consensual.

8. VISUAL FIELDS - Record results and type of test performed *(Attach field charts, if used)*

9. OPTHALMOSCOPIC - Describe any variations from normal in either eye on funduscopic examination.

10. SLIT LAMP - Record results of slit lamp examination of each eye where indicated.

11. INTRAOCULAR PRESSURE - Record results and method used.

A. METHOD USED	O.D.	O.S.

12. VISUAL ACUITY *(Use Snellen Equivalents)*

	TEST METHOD	UNCORRECTED OD OS OU	LENSES USED	CORRECTED VISUAL ACUITY OD OS OU
A. NEAR VISION (16 INCHES)			CONTACT LENSES GLASSES ONLY GLASSES WITH CONTACTS	
B. INTERMEDIATE VISION (32 INCHES)			CONTACT LENSES GLASSES ONLY GLASSES WITH CONTACTS	

NOTE - If contact lenses are used, corrected near visual acuity should be determined while these lenses are worn. Indicate if the contact lenses used (if any) were bifocal:

	TEST METHOD	UNCORRECTED OD OS OU		OD OS OU
C. DISTANT VISION			CONTACT LENSES GLASSES	

13. PRESENT PRESCRIPTION *(Sphere, cylinder, axis)*			
A. CONTACT LENSES		B. GLASSES	
OD	OS	OD	OS

IF CONTACT LENSES ARE NOT USED, OMIT ITEMS 14-16

14. TYPE OF LENSES *(Corneal, acleral, lenticular, single-cut, bifocal, toric, non-rotating, special shape, etc.)*

15. EXAMINATION FREQUENCY - Indicate frequency of periodic followup examination.

16. SYMPTOMS OR ABNORMAL CONDITIONS -Note any lacrimation, photopobia, loss of lens, or evidence of corneal injury or edema, etc., requiring treatment and/or interruption of contact lens wearing. State results of slit lamp or biomicroscopic examination of cornea.

17. PROFESSIONAL EVALUATION - Indicate your professional opinion and any other comment or additional observations.

18A. TYPED NAME AND ADDRESS OF EYE SPECIALIST	18B. SIGNATURE OF EYE SPECIALIST