Comprehensive Visual Assessment

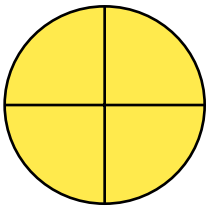
PATIENT NAME:_____ DOB:_____

DATE:_____

SUBJECTIVE REPORT/CLINICAL OBSERVATIONS

Floaters	Double vision	Running into walls/objects
Blurred vision	Light sensitivity	Difficulty reading
Fluctuation in vision	Ptosis	Nystagmus
Difficulty distinguishing color	Excessive tearing	Headaches
Shadows or dark spots in vision	Loss of vision	Other:_____

VISUAL FIELDS



Right: _____

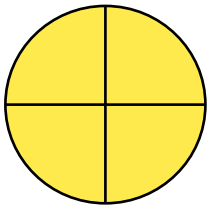
_____

_____

_____

_____

_____



Left: _____

_____

_____

_____

_____

_____

CONTRAST SENSITIVITY SCREEN

H T O A R C

VISUAL ACUITY

Distance vision: R:_____ L:_____ B:_____ *(compare to known baseline)*

OCULOMOTOR ASSESSMENT

VOR	☐ WFL	☐ IMPAIRED	_____
Head Thrust	☐ WFL	☐ IMPAIRED	_____
Smooth Pursuits	☐ WFL	☐ IMPAIRED	_____
Gaze-evoked Nystagmus	☐ WFL	☐ IMPAIRED	_____
Saccades	☐ WFL	☐ IMPAIRED	_____
Fixation	☐ WFL	☐ IMPAIRED	_____
Near Point Convergence	☐ WFL	☐ IMPAIRED	_____
Cover Test	☐ WFL	☐ IMPAIRED	_____

CLINICAL ASSESSMENT

_____

_____

_____

_____

_____

REFERALS/RECOMMENDATIONS

☐ Referal to Optometrist/ Neuro-Optometrist	☐ Vestibular Assessment
☐ Referal to Neuro-Opthalmologist	☐ Perceptual Assessment
☐ Low vision therapy/devices	☐ Cognitive Assessment
☐ Vision therapy/compensatory strategies	☐ Patient/Caregiver Education

SINGATURE:_____ DATE/TIME:_____