PERSONAL DETAILS
Name: __________________________________________
Area/Village/School: __________________________________________
Age: __________________________________________
Eye problem: __________________________________________

Are glasses normally worn? □ Near □ Distance

VISUAL ACUITY
Distance presenting (without glasses) _______ _______ _______
Distance corrected (with glasses) _______ _______ _______
Near (both eyes) ________________ at a distance of ______ cm

VISUAL FIELD
☐ All sides good ☐ Not possible to test
Limited
☐ Right ☐ Left ☐ Up ☐ Down ☐ Centre
Colour Vision
☐ Discriminate ☐ Match ☐ Sort
Comments __________________________________________
________________________________________
________________________________________

CONTRAST
☐ Needs good contrast (e.g. dark on light background)
☐ Can work with little light (e.g. light on light background)
Comments __________________________________________
________________________________________
________________________________________

LIGHT
Child/Client likes
☐ Dim Light ☐ Good Daylight ☐ Extra Light (eg Lamp)
Comments __________________________________________
________________________________________
________________________________________