PERSONAL DETAILS
Name: ____________________________________________
School/Organisation/Clinic: ____________________________________________
Age: ____________________________________________
Gender: ____________________________

Are glasses normally worn?  ☐ Near  ☐ Distance

VISUAL ACUITY (VA)

Distance

presenting (without glasses) ____________________ ____________________ ____________________
corrected (with glasses) ____________________ ____________________ ____________________
if VA < 6/18 Pinhole VA ____________________ ____________________ ____________________

Near
both eyes (with glasses if used) ________ at a distance of ________ cm

REMARKS (Complaints, previous treatment/operations, observations)
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Name of Tester: ____________________________
Date: ____________________________