

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				
A. WITHOUT CORRECTION	(1) AT 20 FEET EXO. ESO. HYPER.		(2) AT 18 INCHES EXO. ESO. HYPER.	
B. WITH CORRECTION (if any)	(1) AT 20 FEET EXO. ESO. HYPER.		(2) AT 18 INCHES EXO. ESO. HYPER.	
6. FUSION - Estimate fusion ability and state methods used in examination. (<i>Red lens, etc.</i>)				
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 (<i>Attach field charts, if used</i>)				
9. OPHTHALMOSCOPIC - 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 (<i>Use Snellen Equivalents</i>)			LENSES USED	CORRECTED VISUAL ACUITY
A. NEAR VISION (16 INCHES)	TEST METHOD	UNCORRECTED OD OS OU	CONTACT LENSES	OD OS OU
			GLASSES ONLY	
			GLASSES WITH CONTACTS	
B. INTERMEDIATE VISION (32 INCHES)	TEST METHOD	UNCORRECTED OD OS OU	CONTACT LENSES	OD OS OU
			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:				
C. DISTANT VISION	TEST METHOD	UNCORRECTED OD OS OU	CONTACT LENSES	OD OS OU
			GLASSES	

13. PRESENT PRESCRIPTION (<i>Sphere, cylinder, axis</i>)			
A. CONTACT LENSES		B. GLASSES	
OD	OS	OD	OS
<i>IF CONTACT LENSES ARE NOT USED, OMIT ITEMS 14-16</i>			
14. TYPE OF LENSES (<i>Corneal, acleral, lenticular, single-cut, bifocal, toric, non-rotating, special shape, etc.</i>)			
15. EXAMINATION FREQUENCY - Indicate frequency of periodic followup examination.			
16. SYMPTOMS OR ABNORMAL CONDITIONS -Note any lacrimation, photophobia, 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	