

U.S. DEPARTMENT OF TRANSPORTATION - FEDERAL AVIATION ADMINISTRATION						1. DATE				
REPORT OF EYE EVALUATION										
2A. NAME OF AIRMAN (Last, First, Middle)				2B. DATE OF BIRTH (Month, Day, Year)		2C. SEX (M or F)				
3. ADDRESS OF AIRMAN (No. Street, City, State, Zip Code)										
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			(2) AT 18 INCHES				
			EXO.	ESO.	HYPER.	EXO.	ESO.	HYPER.		
B. WITH CORRECTION (If any)			(1) AT 20 FEET			(2) AT 18 INCHES				
			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 accommodation and light, direct and consensual.										
8. VISUAL FIELDS--Record results and type of test performed. (Attach field charts, if used).										
9. OPHTHALMOSCOPIC--Describe any variations from normal in either eye on fundoscopic examination										
10. SLIT LAMP--Record results of slit lamp examination of each eye where indicated.										
11. INTRAOCULAR PRESSURE--Record results and methods used.										
A. METHOD USED						O.D.		O.S.		
12. VISUAL ACUITY (Use Snellen Equivalents)						LENSES USED		CORRECTED VISUAL ACUITY		
A. DISTANT VISION		TEST METHOD	UNCORRECTED			CONTACT LENSES		O.D.	O.S.	O.U.
			O.D.	O.S.	O.U.					
B. NEAR VISION (16 INCHES)		TEST METHOD	UNCORRECTED			CONTACT LENSES ONLY		O.D.	O.S.	O.U.
			O.D.	O.S.	O.U.	GLASSES ONLY				
						GLASSES WITH CONTACTS				
C. INTERMEDIATE VISION (32 INCHES)		TEST METHOD	UNCORRECTED			CONTACT LENSES ONLY		O.D.	O.S.	O.U.
			O.D.	O.S.	O.U.	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.										

13. PRESENT PRESCRIPTION (<i>Sphere, cylinder, axis</i>)			
A. CONTACT LENSES		B. GLASSES	
O.D.	O.S.	O.D.	O.S.
<i>IF CONTACT LENSES ARE NOT USED, OMIT ITEMS 14-19.</i>			
14. TYPE OF LENSES (<i>Corneal, scleral, 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 obiomicroscopic 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	