ABDD VISION CARE FORM

Name:	DOB:	Date and Time of Appointment:
Address:		Guardian (if applicable):
Insurance Information and MA#:		
Allergies/Sensitivities:		
Health Care Provider:		Phone:
Address:		Specialty:
Current Medications:		

VISUAL ACUITY

	R EYE @ distance	L EYE @ distance	R EYE @ reading distance	L EYE @ reading distance
Without Glasses	20/	20/	20/	20/
With Glasses	20/	20/	20/	20/

BINOCULAR EFFICIENCY

Description	*Adequate*	*Inadequate*
Maintenance of Binacular Fixation		
Ability to maintain focus at near		
Ability to change focus quickly and easily		
Ocular Motility (ability to move freely in all directions)		
Binocular Depth Perception		
Color Perception		

Overall Eye Health:

Are new glasses recommended at this time? ☐ **yes** ☐ **no**

How frequently are they recommended to be worn (please circle):

Constantly *Reading* *Distance* *Movies* *Television* *Work* *Desk Work*

Return Visit Needed ☐ **yes** ☐ **no**

If return visit is needed, date and time of follow up appointment: ______________________________

Other Recommendations:

☐ Completed Report Returned to Medical Assistant
☐ Appointment Recorded on Daily Log
☐ New frames/lenses picked out

COMMENTS:

Health Care Provider Signature: **Date:**

Staff Print Name (person accompanying individual to appointment):