Examination form Amblyopia

Date of Birth:	Patient name:
Patient Phone:	Patient address: _______________ Patient e-mail:

Baseline Examination:

Present Rx

Please mark the correct box

Spectacles	CL	None

Current Spectacles Rx

		Sph	Cyl	Axis	Add
Distance	RE				
	LE				
Near	RE				
	LE				

Visual Acuity

		With current Rx	Without Rx
Distance	RE	20/	20/
	LE	20/	20/

Subjective Refraction

		Sph	Cyl	Axis
Distance	RE			
	LE			

Objective Refraction

	Sph	Cyl	Axis
RE			
LE			

BCVA Near

	Snellen	Jaeger	# letters missed
RE	20/		
LE	20/		

Cover Uncover Test

	Tropia	Phoria	None
Prism ° diopter			

Worth 4- Dot

Suppression	Diplopia	Fusion	Rivalry (alternating)

TITMUS FLY/ RANDOT

STEREO TEST (Optional)

Seconds of Arc:

SINE WAVE CONTRAST TEST (Optional)

Right

9					
8					
7					
6					
5					
4					
3					
2					
1					
None					
	1.5	3	6	12	18

Left

9					
8					
7					
6					
5					
4					
3					
2					
1					
None					
	1.5	3	6	12	18

Are there any ocular disease? Yes/No

Please detail____

Name of practitioner: ____ Signature:____________________________

Clinics contact number: _________________________________ E-mail:_______________________________________

Date of examination: ___________________________________