OMB Control No. 2120-0034
Expires 10/31/2024

U.S. DEPARTMENT OF TRANSPORTATION – FEDERAL AVIATION ADMINISTRATION

REPORT OF EYE EVALUATION

1. DATE	

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 past and present history concerning visual problems, eye surgical procedures, and medical conditions.

5. **HETEROPHORIA** – Record phorias and tropias (specify which) in prism diopters, with and without best lens correction in place

	(1) AT 20 FEET			(2) AT 16 INCHES		
A. WITHOUT CORRECTION	EXO.	ESO.	HYPER.	EXO.	ESO.	HYPER.
	(1) AT 20 FEET			(2) AT 16 INCHES		
B. WITH CORRECTION *(If any)*	EXO.	ESO.	HYPER.	EXO.	ESO.	HYPER.

6. **FUSION AND EOM** – Record fusion ability and method used. Note presence of strabismus, diplopia, and/or abnormal extraocular motility.

7. **PUPILS** – Statement of relative size and reaction. Specify abnormal function i.e. afferent pupillary defect.

8. **VISUAL FIELDS** – Attach field charts, if used.

9. **EXTERNAL AND SLIT LAMP EXAM** – Record results of slit lamp exam for each eye. Describe corneal scars or cataracts, if present. Describe abnormal adnexa findings.

O.D.

O.S.

10. **OPHTHALMOSCOPIC** – Describe disc, macula, vessels, and retina. State if dilated exam performed.

O.D.

O.S.

11. VISUAL ACUITY *(Use Snellen Equivalents)*		WITHOUT CORRECTION	WITH CORRECTION	CHECK IF APPLICABLE: CONTACT LENSES	CHECK IF APPLICABLE: SPECTACLE LENSES
A. DISTANT VISION	O.D.				
	O.S.				
B. NEAR VISION *(16 INCHES)*	O.D.				
	O.S.				
C. INTERMEDIATE VISION *(32 INCHES)*	O.D.				
	O.S.				

NOTE – If contact lenses are used, corrected near visual acuity should be determined while these lenses are worn. State if bifocal or monovision contact lens(es) are used.

12. **INTRAOCULAR PRESSURE** – State method used.

O.D.	O.S.

13. **PRESENT PRESCRIPTION** *(Sphere, cylinder, axis)*

A. CONTACT LENSES		B. SPECTACLE LENSES	
O.D.	O.S.	O.D.	O.S.

13A. **DESCRIBE TYPE OF CONTACT LENSES USED.**

14. **EYE SURGERIES** – List all procedures with dates, indications, and sequelae. If cataract surgery was performed, include type and name of intraocular lens(es) used.

15. **EYE MEDICATIONS** – Include dosage, and whether O.D./ O.S / O.U.

16. **PROFESSIONAL EVALUATION** – Provide diagnosis, prognosis, comments on other findings, and recommendations for followup.

17A. TYPED NAME AND ADDRESS OF EYE SPECIALIST	17B. SIGNATURE OF EYE SPECIALIST