VISION SCREENING

DATE OF SCREENING: _____ SCREENER: _____

ALLERGIES: _____ CURRENT MEDICAL PROBLEMS: _____

_____

_____

PLEASE ANSWER EACH QUESTION BELOW PLEASE CIRCLE ONE

1. Do you wear glasses or contacts at present: Yes No
   If yes, (circle one) (distance) (near) (all the time)
   How long have you had glasses? Contacts? _____
   When did you have your last eye exam? _____
2. Do you have reason to believe that you have an eye and/or vision problem? Yes No
   If yes, describe your problem, including how long have you had the problem?
   _____
   _____
3. Does your vision problem cause you difficulty reading or writing? Yes No
4. Do you have difficulty watching TV without glasses? Yes No
5. Do you have a prosthetic eye? Yes No
   Which eye? _____
6. Do you have or get headaches? If yes, how often? _____ Yes No
7. Are you under treatment for any eye condition at present? Yes No
   What condition? _____Treatment? _____
8. Have you ever lost your sight, even for just a few moments? Yes No
9. Have you ever had an injury to your eye(s)? If yes, when? _____ Yes No
10. Do you request training for use of a blind cane? Yes No

Visual Acuity Test

	Right Eye w/o glasses	Left Eye w/o glasses	Right Eye w/glasses	Left Eye w/glasses
Far:	_____	_____	_____	_____
Near:	_____	_____	_____	_____

Tonometry Screening for Glaucoma

Right Eye_____ Left Eye _____

Disposition

_____ Refer to optometrist due to visual disturbance per _____

(Attending Clinician Signature/Stamp)

_____ No referral indicated by the results of screening. Inmate educated to address complaints at sick call or Periodic Screenings.

INMATE NAME: _____ _____

DC#:_____RACE:_____ SCREENER SIGNATURE/STAMP

DATE OF BIRTH: _____

INSTITUTION: _____