Amblyopia baseline examination form

Date of birth:	Patient name:

Patient Phone:	Patient home address:

Patient gender	Patient email

Amblyopic Eye

Left	Right	Both

Amblyopia Type
Mark the correct choice

Strabismic	From Deprivation	Anisometropic & Strabismic
Anisometropia	MonoFixation	Unknown

Present Rx Type
Mark the correct box

Glasses	CL	None

Current Spectacles Rx

	SPH	CYL	AXIS	ADD
Distance RE				
LE				

Visual Acuity

	With Current Rx	Without Rx
Distance RE		
LE		

Subjective Refraction

	SPH	CYL	AXIS	BCVA	# missed letters
Distance RE					
LE					

		SPH	CYL	AXIS
Objective Refraction	RE			
	LE			

		# missed letters
BCVA Near	RE	
	LE	

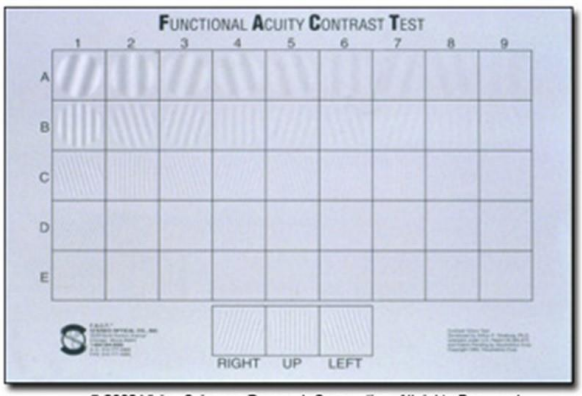
Eye Deviation	Prism Diopters	Phoria	Tropia	Ortho
Cover Test CC				

Worth 4- Dot	Suppression	Fusion	Diplopia	Alternating

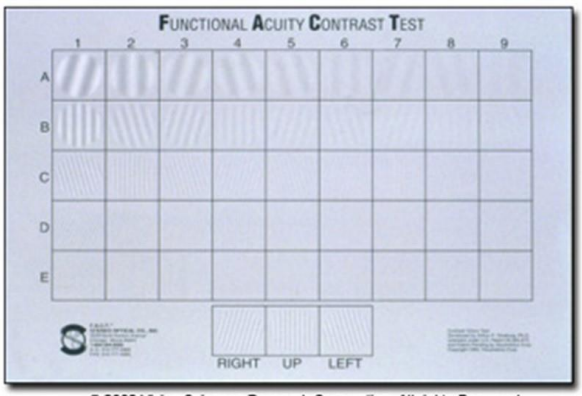
	Seconds of Arc
TITMUS FLY	
STEREO TEST (Optional)	

FACT SINE WAVE CONTRAST TEST (Optional)

RE



LE



Is there any ocular disease? Yes/No Date of examination: _____

Please detail: _____

Name of practitioner: _____ Signature: _____

Clinics contact number: _____ E-mail: _____

Amblyopia periodic follow up examination form

		# missed letters	
BCVA Distance	RE		
	LE		

		# missed letters	
BCVA Near	RE		
	LE		

Worth 4- Dot	Suppression	Fusion	Diplopia	Alternating

	Seconds of Arc
TITMUS FLY	
STEREO TEST (Optional)	

FACT SINE WAVE CONTRAST TEST (Optional)

RE

LE

Date of examination: _____

Name of practitioner: _____ Signature: _____

Clinics contact number: _____ E-mail: _____