

Eye Exam

Date exam scheduled: _____ (This means the date you made the phone call to schedule the appointment)

Date exam performed: _____

Patient: _____

Address: _____

City: _____ **Zip Code:** _____

		Sphere	Cylinder	Axis	Prism	Base	Decentration	
							In	Out
Distance	R							
	L							

		Segment	Height	Width	Inset	Total Inset and Decentration
		Power				
ADD	R					
	L					

		DBL	Lens Size (box) & Shape
PD	Far		
	Near		

Instructions: _____

Examining Physician Signature: _____

Please Print or Type: _____
 (physician name)

Address: _____

Phone: _____