



Baseline and Post Program Evaluation Form

Patient name: _____

Examination date: _____

Test Results:

Visual Acuity Distance : OD 20/ OS 20/
Visual Acuity Near: OD 20/ OS 20/
Visual Acuity
Distance with +1.00D: OU 20/

Cover Test Distance: Eso Exo Ortho _____ ^
Cover Test Near: Eso Exo Ortho _____ ^

Near Point of Convergence Break (cm):
Near Point of Convergence Recovery (cm):

NRA (+ to blur):
PRA (- to blur):

Anterior Segment Slit lamp
Plugged Meibomian Glands: positive negative
Blinking dysfunction: positive negative

Visual Field 30-2 OD and OS

Color Kinetic Field if available OD and OS

Doctor's name: _____

Doctor's email: _____

Doctor's Signature: _____