SCHOOL OF OPTOMETRY AND VISION SCIENCE
COLLEGE OF HEALTH AND ALLIED SCIENCES
UNIVERSITY OF CAPE COAST
CAPE COAST – GHANA optometry@ucc.edu.gh

EYE SCREENING FORM

Information from these forms (online and paper) may be used for research purposes. Please be assured that all data used for research will be anonymized, ensuring that your personal identity remains confidential.

☐ I consent ☐ I do not consent

IMPORTANT: You need to complete an online pre-screening questionnaire first BEFORE your eye screening. The form is accessible here: https://forms.gle/m5uxh8BEufZ1YpaM8. You will receive a confirmation email after completing the form. Please present this confirmation email for your eye screening.

Date of Eye Examination: ……

Surname:		Index No:
First Name(s):		Programme of Study:
Date of Birth:	Sex: M ☐ F ☐	Phone No:

How OFTEN do you experience the following eye related symptoms?					
Rate the frequency on the scale 0 to 4	0 Never	1 Rarely	2 Sometimes	3 Often	4 Always
Headaches					
Painful eyes					
Tearing					
Photophobia (high sensitivity to sunlight)					
Tired or strained eye					
Itching					
Redness					
Grittiness or sandy sensation					
Blurred vision during near work					
Missing lines when reading					

How SEVERE are these eye related symptoms if you experience them?					
Rate the severity on the scale of 0 to 4	0 Never	1 Mild	2 Moderate	3 Severe	4 V. Severe
Headaches					
Painful eyes					
Tearing					
Photophobia (high sensitivity to sunlight)					
Tired or strained eye					
Itching					
Redness					
Grittiness or sandy sensation					
Blurred vision during near work					
Missing lines when reading					

PLEASE TURN OVER PAGE

FOR CLINICAL USE ONLY

Student's Surname:	Index No:	
First Name(s):	Date of Birth:	Sex: M ☐ F☐

	UNAIDED		+1.00 PH	WITH SPECTACLE RX / CONTACT LENSES					VA	HABITUAL AOA
	@6M	@0.4M		SPH	CYL	AXIS	@6M	@0.4M		
OD										
OS										
OU				DATE OBTAINED						

NPC	**COVER TEST AT NEAR**		**OCULAR MOTILITY**	**PUPILLARY REF**	**CONFRONTATION**
	☐ PHORIA ☐ TROPIA	☐ ESO ☐ EXO ☐ ORTHO	OD OS	DIRECT CONSENSUAL RAPD+	OD OS

OD	**EXTERNALS & MEDIA**	**OS**
	LIDS:	
	LASHES:	
	CONJUNCTIVA:	
	CORNEA:	
	AC:	
	LENS:	
	VITREOUS:	
	OPTIC DISC & RETINA	
	E	
	CDR	
	D	
	LC	
	FR	
OTHER FINDINGS:		

IOP	**TIME:**		**AUTOREF**	
RE	**LE**		**RE**	**LE**

DOCTOR'S REPORT	REASON FOR REFERRAL/Dx:	
REFERRED ☐ NOT REFERRED ☐	☐ Refractive error ☐ Cataract ☐ Glaucoma suspect	☐ Other:
…… SIGNATURE/STAMP	…… DATE OF EXAMINATION	

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FRESH STUDENTS EYE EXAMINATION REPORT

Date of Eye Examination: ……

Surname:			Index No:
First Name(s):			Programme of Study:
Date of Birth:	Sex: M ☐	F☐	Phone No:

UNAIDED VA	
OD	
OS	

AIDED/BEST CORRECTED VA	
OD	
OS	

EXTERNALS	OD:
	OS:
INTERNALS (E/CD/D/LC/FR)	OD:
	OS:
REFRACTIVE STATUS:	
OTHER COMMENT:	

In view of the above findings, I declare him/her:

☐ FIT for admission.

☐ UNFIT for admission.

Signature: _____

OPTOMETRIST/OPHTHALMOLOGIST

