PRE-FIGHT OPHTHALOMOGIC EVALUATION FORM

NAME: _____ **EXAM DATE:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **COUNTRY:** _____

PHONE: _____ **DATE OF BIRTH:** _____

HISTORY

HAS THE APPLICANT EVER HAD ANY OF THE FOLLOWING CONDITIONS?

1) BLURRED VISION ? YES NO

2) SURGICAL EYE PROCEDURES? YES NO

IF YES, PLEASE EXPLAIN:

_____

_____

3) SIGNIFICANT EYE PROBLEM OR INJURY? YES NO

IF YES, PLEASE EXPLAIN:

_____

_____

4) EYE DISEASE? YES NO

IF YES, PLEASE EXPLAIN:

_____

_____

5) DETACHED RETINA? YES NO

IF YES, PLEASE EXPLAIN:

_____

6) LASIK, RK OR PRK CORRECTIVE PROCEDURE? YES NO

IF YES, PLEASE EXPLAIN:

7) RECENT EYE INJURY? YES NO

IF YES, PLEASE EXPLAIN:

Name:_____

PRE-FIGHT OPHTHALOMOGIC EVALUATION FORM

OPHALMOLOGIC EXAMINATION:

VISION: OD: _____/_____ OS: _____/_____ OU: _____/_____ CORRECTED UNCORRECTED

IF CORRECTED, BEST UNCORRECTED VISION: OD: _____/_____ OS: _____/_____ OU: _____/_____

SLIT LAMP EXAM: OD: NORMAL ABNORMAL OS: NORMAL ABNORMAL

DILATED PUPIL: OD: NORMAL ABNORMAL OS: NORMAL ABNORMAL

LIGHT REFLEW: OD: NORMAL ABNORMAL OS: NORMAL ABNORMAL

ACCOMMODATION RELEX: OD: NORMAL ABNORMAL OS: NORMAL ABNORMAL

FUNDI EXAM: OD: NORMAL ABNORMAL OS: NORMAL ABNORMAL

DISC: OD: NORMAL ABNORMAL OS: NORMAL ABNORMAL

MACULAR: OD: NORMAL ABNORMAL OS: NORMAL ABNORMAL

CATARACTS: OD: PRESENT ABSENT OS: PRESENT ABSENT

MOTILITY: OD: NORMAL ABNORMAL OS: NORMAL ABNORMAL

BINOCULAR VISION: OD: NORMAL ABNORMAL OS: NORMAL ABNORMAL

NYSTAGMUS: YES: _____ NO: _____ INTRAOCULAR PRESSURE: OD: _____ OS: _____

COMMENTS:

_____

_____

_____

THE FIGHTER: IS IS NOT MEDICALLY CLEARED TO PARTICIPATE

Physicians Name:
_____

Physician Signature:
_____

Address: _____ City: _____

State: _____ Country: _____ Zip: _____

Phone: _____ Fax: _____