

COASTAL CAROLINA COMMUNITY COLLEGE  
444 WESTERN BOULEVARD  
JACKSONVILLE, NC 28546-6877



**EYE EXAMINATION FORM**

**Patient's Name:** \_\_\_\_\_  
Last First M.I.

**Address:** \_\_\_\_\_  
Street/P.O. Box City State Zip Code

**Home Phone:** (\_\_\_\_) \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**VISUAL ACUITY:**

**SLIT LAMP:**

**FUNDI:** Dilated \_\_\_\_\_

*Please circle one: Conditions **do exist** or **do not exist** in the patient's eyes which would prevent the student from observing laser surgery given the proper eyewear.*

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
M.D./O.D.