DEPARTMENT OF THE ARMY
ARMED FORCES EYE AND VISION READINESS SUMMARY

For use of this form, see DA Pam 40-506; the proponent agency is OTSG.

PRINCIPLE PURPOSE (S): Army personnel are required to have a periodic assessment of visual health and refractive status by an optometrist or ophthalmologist to determine fitness for prolonged duty without ready access to eye and vision care. If the Soldier has had an eye examination within the past 24 months, this form may be completed by the eye care provider to capture the spectacle prescription and eye history data without having to repeat the examination. Measurement of visual acuity is an annual requirement and may be conducted by the unit or in conjunction with the Periodic Health Assessment.

ROUTINE USE (S): Periodic Health Assessment and Vision Readiness Classification.

DISCLOSURE: Voluntary; however, failure to provide the information may result in delays in assessing refractive and vision health needs for military service. Information on this form may also be used to determine Vision Readiness Classification.

1. SERVICE MEMBER'S NAME *(Last, First, Middle Initial)*	2. DATE OF BIRTH	3. BRANCH OF SERVICE

4. UNIT OF ASSIGNMENT	5. UNIT ADDRESS

EXAMINATION RESULTS:
To the Doctor: The individual that you are examining is an Active Duty/National Guard/Reserve member of the United States Armed Forces. We request your assessment of his/her eye and vision health for potential worldwide duty. Please complete the following information, using visual acuity determination, ocular history review, biomicroscopy and refraction as a suggested minimum clinical examination. **This form is meant to determine fitness for prolonged duty without ready access to eye and vision care and is not intended to address the member's comprehensive ophthalmologic or optometric needs.**

6. DATE OF VISION SCREENING *(YYYYMMDD):* DATE OF SPECTACLE RX *(YYYYMMDD):*

(1) UNCORRECTED DISTANCE VISUAL ACUITY	(2) BEST CORRECTED DISTANCE VISUAL ACUITY
Right Eye 20/	Right Eye 20/
Left Eye 20/	Left Eye 20/
Both Eyes 20/	Both Eyes 20/

(3) IF ≥ 45, UNCORRECTED NEAR VISUAL ACUITY	(4) IF ≥ 45, BEST CORRECTED NEAR VISUAL ACUITY
Both Eyes 20/	Both Eyes 20/

(5) SPECTACLE PRESCRIPTION (MINUS CYLINDER FORMAT, IF NEAR VISION ONLY ANNOTATE IN BIFOCAL FORM): _____

	SPHERE	CYLINDER -	AXIS	ADDITION +	PRISM
Right Eye					
Left Eye					

(6) PUPILLARY DISTANCE: FAR _____ mm NEAR _____ mm

(7) Does the patient have any ocular condition(s) that may present problems in austere environments far removed from routine medical care?

YES ☐ If yes, please state condition(s):
NO ☐

(8) Will the patient require a 180-day supply of medication(s) to treat an ophthalmologic condition(s)?

YES ☐ If yes, please provide medication(s) and dosage(s):
NO ☐

(9) Has the patient undergone a refractive surgical procedure(s) in the past?

YES ☐ If yes, please provide month, year and type of procedure(s):
NO ☐

7. DOCTOR'S PRINTED NAME	8. STATE LICENSE NUMBER	9. DOCTOR'S ADDRESS & TELEPHONE OR E-MAIL ADDRESS
10. DOCTOR'S SIGNATURE		