Occupational Vision Screening

Vision Screening Recording (Classroom)

Addendum 7

Addendum 7

Vision Screening Questionnaire Recording (Classroom)

Vision Screening Questionnaire – Page 1

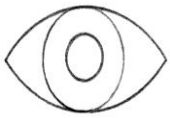
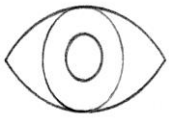
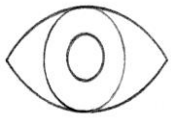
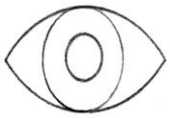
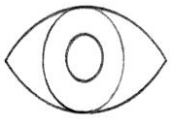
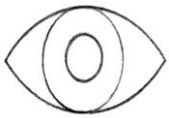
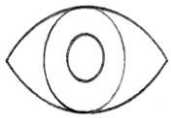
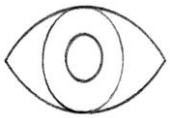
Demographics								
Company								
Title, Full Names, Surname								
ID / Passport No			Employee / File No					
Date of Employment			Gender	Male		Female		
Department								
Job Titles								
Type of Evaluation	Date		Date		Date		Date	
Entry								
Screening								
Periodic								
Exit								
Optometrist - Referred								
Personal Information								
Person / Task Specification Attached								
Marital Status								
Home Address								
Contact Numbers								
Medical Aid Scheme and No								
Hazards (UV, chemicals, sparks, dust)								
Use and knowledge of PPE								
Previous Employment								

Company	Date From	Date To	Job Title	Exposure to Visual Hazards	PPE Used (Yes/No)	Other Exposures

Vision Screening Questionnaire – Page 2

	Year:		Year:		Year:		Year:	
	Yes	No	Yes	No	Yes	No	Yes	No
General Health History - Have you ever suffered from:								
Head injury/trauma/concussion								
Trauma to the eyes								
Discharge from eyes								
Eye infections								
Surgery to eyes								
Painful/irritable eyes								
If yes to any of the above - provide details								
Were you born with any eye problems / impairment?								
If Yes: what								
Do you use any eye medication (drops, gels or other)								
If Yes: what / dosage / from when								
Other medication except chronic medication (lately)								
If Yes: what / dosage / from when								
Ocular History								
Have you ever had your eyes tested before?								
When was the last test?								
When did you change your glasses or contact lenses?								
What is the reason for glasses or contact lenses?								
Family History								
Does a direct family member have any visual problem?								
If Yes: what and who?								
Chronic Medical History								
Do you suffer from any chronic diseases?								
Hypertension								
Diabetes								
High Cholesterol								
Glaucoma / Macular Degeneration / Other								
If Yes: what / from when								
Current medication:								
If Yes: what / dosage / from when								
If Yes: what / dosage / from when								

Vision Screening Questionnaire – Page 3

		Year:		Year:		Year:		Year:	
		Yes	No	Yes	No	Yes	No	Yes	No
Exposures (Sports and Hobbies)									
Do you like to watch TV and movies on your phone?									
Do you play computer games? How often?									
Do you wear vision protection for sports and hobbies?									
Do you regularly do any of the following: (circle the applicable) Shooting / Lawnmowing / Metal Work / Swimming / Woodwork / Chain Sawing / Welding / OTHER:									
Exposures (Work Related)									
Are you routinely exposed to visual hazards in your job?									
Daily duration - how many hours (daily/weekly/monthly)		Average hours:		Average hours:		Average hours:		Average hours:	
What type of visual protective device do you use?									
Physical Examination									
LEFT EYE	Iris / Sclera / Conjunctiva / Pupil / Tear Duct / Eyelids / Eyelashes / eyebrows								
RIGHT EYE	Iris / Sclera / Conjunctiva / Pupil / Tear Duct / Eyelids / Eyelashes / eyebrows								

Recommendations				
1. Educate				
2. Investigate(EAP)				
3. H&S Committee - how reported				
4. COIDA				
5. Fit for Duty				
I hereby declare that all the information furnished above is, to the best of my knowledge, true and correct and that no information has been omitted or withheld. I hereby give consent to undergo medical surveillance and that the results may be made available to the necessary persons.				
Employee signature				
Vision Screening technician signature				
Date				

Non-Automated Vision Screening Recording (Classroom)

Vision Screening Examination			Uncorrected			Corrected			
Assessment		Test Conducted	Right Eye	Left Eye	Both Eyes	Right Eye	Left Eye	Both Eyes	Outcome / Interpretation
1	Pupil Reaction	PEARLA							
2	Corneal Reflex	Blink reflex							
3	Light Reflex	Hirschberg Test							
4	Convergence	Convergence and Divergence							
5	Cardinal Muscles	9 Cardinal Fields of Gaze							
6	Colour Vision	Ishihara Plates							
7	Visual Fields	Confrontation / Novissphere							
8	Depth Perception	Beads / Water / Lang / Needle							
9	Near Visual Acuity	Jaeger / Sloan / Rosenbaum							
10	Far Visual Acuity	Snellen / Tumbling E							

Automated Vision Screening Recording (Classroom)

Vision Screening Examination			Uncorrected			Corrected			
Assessment		Test Conducted	Right Eye	Left Eye	Both Eyes	Right Eye	Left Eye	Both Eyes	Outcome / Interpretation
1	Pupil Reaction	PEARLA							
2	Corneal Reflex	Blink reflex							
3	Light Reflex	Hirschberg Test							
4	Convergence	Convergence and Divergence							
5	Automated Test	Keystone / Titmus / Depisteo / Other							