



MOHEGAN TRIBE
DEPARTMENT OF ATHLETIC REGULATION
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 OPHTHALMOLOGIC EVALUATION FORM

OPHTHALMOLOGIC EXAMINATION:

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

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

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

DILATED PUPIL: OD: NORMAL ABNORMAL OS: ~~NORMAL~~ NORMAL

LIGHT REFLEW: OD: ~~NORMAL~~ NORMAL OS: ~~NORMAL~~ NORMAL

ACCOMMODATION RELEX: OD: ~~NORMAL~~ NORMAL OS: ~~NORMAL~~ NORMAL

FUNDI EXAM: OD: ~~NORMAL~~ NORMAL OS: ~~NORMAL~~ NORMAL

DISC: OD: ~~NORMAL~~ NORMAL OS: ~~ABNORMAL~~ ABNORMAL

MACULAR: OD: ~~NORMAL~~ NORMAL OS: ~~NORMAL~~ NORMAL

CATARACTS: OD: PRESENT ABSENT OS: ~~PRESENT~~ ABSENT

MOTILITY: OD: ~~NORMAL~~ NORMAL OS: ~~NORMAL~~ NORMAL

BINOCULAR VISION: OD: ~~NORMAL~~ NORMAL OS: ~~NORMAL~~ NORMAL

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: _____