Sleep Apnea
Eye Study
Retinal Photography
Completion Form

ID Number: __ __ __ __ __

Photographer Initials: __ __

Date: __ __ / __ __ / __ __

This form should be completed for each participant at the time photos are taken. Retain the original at the clinic and fax to: Jennifer Reinke (608) 265-3718

Eye Vision History Questionnaire completed: __ __ / __ __ / __ __ Not Done

Image No.	Pupil Size (mm)	Flash	OD / OS	Gated?	F1	F2	Other
1			OD / OS		F1	F2	
2			OD / OS		F1	F2	
3			OD / OS		F1	F2	
4			OD / OS		F1	F2	
5			OD / OS		F1	F2	
6			OD / OS		F1	F2	
7			OD / OS		F1	F2	
8			OD / OS		F1	F2	
9			OD / OS		F1	F2	

Comments: