Building healthy communities
HOLYOKE HEALTH

Getting Ready for Your Eye Exam at

Holyoke Health Center Vision Center Disability Eye Care Services

267 High Street, Holyoke MA 01040-6585 P: 413-420-2825 F: 413-533-0472

Please SEND the following prior to your exam:	**Please BRING the following to your exam:**
• Copies of updated Health Care Record	• Any current eyeglasses and sunglasses
• List of current allergies and medications	• Any low vision devices currently used
• Copies of any prior eye exams	• Report forms to be filled out by the Doctor
• THIS completed Form	• Your insurance car

Your Personal Information:

Today's Date:

Name:_____

Date of Birth:

Preferred Name:_____

Age:_____

Preferred Pronoun: ☐ His/Him ☐ She/Her ☐ They/Them Other:_____

Address:_____

Sex at birth:_____

_____

Gender:_____

Preferred Phone:_____

Name of Primary Caregiver:_____

Primary Care Physician:_____Last Medical Exam: ___ /___ /____

Primary Care Physician address:_____Phone:_____

Pharmacy/Location_____Phone:_____

Help Us Prepare for your Visit:

Do you use any mobility devices? ☐ Wheelchair ☐ Walker ☐ Cane

What is the best way to communicate with you? ☐ Verbal ☐ Non-verbal

Do you need a translator? ☐ Language: ☐ ASL ☐ Other

What is the reason for today's exam? Please check/select all that apply.

☐ Blur at Distance	☐ Dry Eyes	☐ Eye Turn
☐ Blur at Near	☐ Red Eyes	☐ Diabetic Exam
☐ Vision Loss	☐ Discharge	☐ Broken Glasses
☐ Flashes/Floaters	☐ Headache	☐ Routine Exam
☐ Eye Pain	☐ Double Vision	☐ Other:

Your History:

Last Eye Exam: Doctor's name & Location:_____

Do you currently wear glasses? ☐ **Y** ☐ **N** How old are your current glasses?_____

Are you registered as Legally Blind with the Mass. Commission for the Blind? ☐ **Y** ☐ **N**

Do you have or have your been treated for the following **eye** conditions?

☐ Glaucoma	☐ Cataracts	☐ Dry Eyes
☐ Macular Degeneration	☐ Eye Injury	☐ Lazy Eye/Eye Turn
☐ Retinal Detachment	☐ Retinal Disease	☐ Other:_____
Have you had any eye surgeries? ☐ **Y** ☐ **N** Explain:		
Do you take any eye medications? ☐ **Y** ☐ **N** Which ones:		
Have you been diagnosed with Cortical/Cerebral Visual Impairment (CVI)? ☐ **Y** ☐ **N**		

Do you have or have your been treated for the following **medical** conditions?

☐ Neurological Disorder	☐ Diabetes	☐ Breathing problems
☐ Autism spectrum	☐ High Blood Pressure	☐ Allergy/Immune disorder
☐ Seizure Disorder	☐ High Cholesterol	☐ Cancer
☐ Developmental Delay	☐ Heart Disease	☐ Headaches
☐ Anxiety	☐ Thyroid Disease	☐ Other:
Please list Diagnosis (if known) related to any Disability:		

Your Family History:

Do any members of your immediate family have any of the above **eye** or **medical** conditions?

Please List:

Please list any additional concerns you may have for your eye visit:

Thank you! We look forward to serving your eye care needs.