

Getting Ready for Your Eye Exam

Please be sure to bring with you to the eye exam:

- Updated Health Care Record and lists of your current medications and allergies
- Eye glasses and sunglasses that you currently wear
- Copies of recent Eye Exam Reports that you may have
- **This form: Please gather information for this communication tool together with your caregivers and staff who know you best at home and at your work/day program.**

Your Personal Information		Today's Date: <u> </u> / <u> </u> / <u> </u>	DOB: <u> </u> / <u> </u> / <u> </u>	
Your Name and Address:	Phone:	Email:		
Primary Caregiver:	Phone:	Email:		
Who helped you fill out this form? At Home, Name & Position:	Phone:	Email:		
At Day/Work Program, Name & Position:	Phone:	Email:		
What are your reason(s) for visiting the Eye Care Provider:				
About Your Medical History, Eye History and Vision Care				
Primary Care Physician: Address: Phone: Date of Last Exam:	Most Previous Eye Care Provider: Address: Phone: Date of Last Exam:			
Please List Medical History :	Please List Eye History :			
Please List Diagnosis (if known): related to intellectual disability:	Family Eye & Medical History:			
Are you registered as Legally Blind, with the Massachusetts Commission for the Blind? (Please circle.)				
YES		NO	Do Not Know	
Do you have trouble seeing? (Please circle.)				
YES		NO	Do Not Know	
Have You Experienced Any Recent Changes?				
	YES	NO	Do Not Know	If YES, please describe:
Have you lost interest in favorite activities?				
Are you no longer able to perform daily living activities?				
Have you had any recent accidents or injuries?				

About Your Eyes					Location Observed			Lighting Level		
Do you...	No	Yes Right Eye Only	Yes Left Eye Only	Both Eyes	Home	Work	Day Program	Bright	Medium	Dim
Have red eyes?										
Have drainage in eye area?										
Have crusty eyes?										
Have watery eyes?										
Cover/close one eye to see?										
Prefer eyes closed?										
Frequently touch/rub eyes?										
Complain of eye pain?										
Press down on eyes?										

Eye Glasses / Sunglasses / Eye Protection						
Do you wear eyeglasses? Please circle: YES NO Do Not Know			Do you wear/use:	YES	NO	Do Not Know
If YES, how many pairs do you have? _____			Bifocals			
When do you wear eyeglasses? Please circle: During awake hours Distance only Close only			Transition Lenses			
How do you tolerate glasses? Please circle: No Problems Short Periods of Time Do Not Tolerate			Hat/Visor (outside)			
			Sunglasses (outside)			
			Sunglasses (inside)			

Understanding Your Skills for the Eye Exam			
	YES	NO	Do Not Know
Can you identify better or worse?			
Can you identify the alphabet?			
Can you identify numbers?			
Can you identify colors?			
Can you identify shapes?			
Can you perform matching? If YES, do you prefer 2 or 4 symbols?			

Helping the Eye Care Provider for Your Visit				
What is the best way for the doctor to communicate with you?				
In the past, how long have you been able to sit with the doctor for eye exams?				
Are you planning to take any pre-sedation medication prior to coming to your exam? YES NO Do Not Know				
Do you use any mobility devices? (Please check all that apply.)		YES	NO	Do Not Know
Wheelchair				
Walker				
Support Cane				
Long Cane				
Push Cane				

Please describe any vision concerns that you have at home:

Please describe any vision concerns that you have at your day program or work place:

Please describe any vision concerns that you have in the community:

Please list any questions you have for the Eye Doctor:

Please list any current medications you are taking:

Please list any known allergies:

Do you smoke? Have you smoked in the past?

Please complete this page if you answered YES to any question on Page 1.

More About Your Eyes										
Do you...	No	Yes	Unsure	Recent Change	Location Observed			Lighting Level		
					Home	Work	Day Program	Bright	Medium	Dim
Appear to be light sensitive?										
Appear to need more light?										
Squint frequently?										
Squint when watching television?										
Squint when looking at something close up?										
About Your Use of Vision										
Do you...	No	Yes	Unsure	Recent Change	Location Observed			Lighting Level		
					Home	Work	Day Program	Bright	Medium	Dim
Tilt or turn head when looking?										
Appear unable to make direct eye contact?										
Frequently knock over items unintentionally?										
Frequently move items closer / farther from eyes?										
Over or under reach for objects?										
Miss food on the plate when eating?										
Have difficulty locating dropped objects?										
Act confused or disoriented in familiar locations?										
Frequently bump into objects or furniture?										
Reach for wall or furniture when walking?										
Frequently trip or fall when walking?										
Use your foot to locate the edge of a curb or step?										
Overstep or shuffle feet when walking?										
Hesitate when walking over uneven surfaces?										
Hesitate at change in surface color?										