Getting Ready for Your Eye Exam

Please send to the clinic prior to your eye exam:
- Copies of Updated Health Care Record and lists of your current medications and allergies
- Copies of recent Eye Exam Reports that you may have
- This completed 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.

Please bring to the eye exam: Eye glasses and sunglasses that you currently wear

Your Personal Information	**Today's Date: __/__/____**	**DOB: __/__/____**
Your Name and Address:	Phone:	Email:
Primary Caregiver:	Phone:	Email:
Who helped you fill out this form? At Home, Name & Position: At Day/Work Program, Name & Position:	Phone: Phone:	Email: 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

Do you…	No	Yes Right Eye Only	Yes Left Eye Only	Both Eyes	Location Observed: Home	Location Observed: Work	Location Observed: Day Program	Lighting Level: Bright	Lighting Level: Medium	Lighting Level: 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

If YES, how many pairs do you have? _____

When do you wear eyeglasses? Please circle:
During awake hours Distance only Close only

How do you tolerate glasses? Please circle:
No Problems Short Periods of Time Do Not Tolerate

Do you wear/use:	YES	NO	Do Not Know
Bifocals			
Transition Lenses			
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										
					Location Observed			Lighting Level		
Do you…	No	Yes	Unsure	Recent Change	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										
					Location Observed			Lighting Level		
Do you...	No	Yes	Unsure	Recent Change	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?										