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	ur Personal Information To				oday's Date: _/_/ DOB: _/_/						
Your Name and Address:			Phone:	Em	ail:						
Primary Caregiver:			Phone:	Em	ail:						
Who helped you fill out this form? At Home, Name & Position:	?		Phone:	En	nail:						
At Day/Work Program, Name a	ו:	Phone:	En	nail:							
What are your reason(s) for visiti	ng the Ey	e Care	Provider:								
About Your Medical History, Ey	ve Histor	Vision Care									
Primary Care Physician:	-		us Eye Care I	Provider							
Address:		Address:									
Phone:		Phone:									
Date of Last Exam:		Date of Last Exam:									
Please List Medical History:			Please List E	ye History:							
Please List Primary Diagnosis (if		Family Eye 8	Medical Histo	ory:							
Are you registered as Legally Blind, with the Massachusetts Commission for the Blind? (Please circle.) YES NO Do Not Know											
(Please circle.)		ES	NO NO								
Do you have trouble seeing? (Please circle.)YESNODo Not KnowHave You Experienced Any Recent Changes?											
			Do Not								
	YES	NO	Know	If YES, pleas	se descrit	be:					
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						ation Ob	oorvod		iabtic		
Do you	No	Yes Right Eye	Yes Left Eye	Both Eyes	Home	Work	Day Day Program	Bria		ghting Lev Medium	
have red eyes?							-				
have drainage in eye area?											
have crusty eyes?											
3 3											
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 / Sunglasse	es / E	ye Prote	ection			1	1				
Do you wear eyeglasses? P YES NO	you wear eyeglasses? Please circle:					u wear/	use:	YES	NO		o Not now
If YES, how many pairs do y	ou ha	ve?			Bifocal	S					
	Transition Lenses						ses				
When do you wear eyeglasses? Please circle: Hat/Visor (outside)						side)					
<u> </u>			<u></u>		1100 113		nuc)				
During awake hours	Distan	ice only	Close o	nly		•					
-		-		nly	Sungla	sses (o	utside)				
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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 Visio	on	L			<u> </u>		I				
					Location Observed			Lightir	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?											