Getting Ready for Your Eye Exam at

MCPHS Eye & Vision Center Developmental Disability Services

10 Lincoln Square, Worcester MA 01608 P: 508-373-5830 F: 508-519-5512

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	• Insurance Card

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.