

Eye Evaluation Sheet



THE LANGSDON CLINIC

Your Name _____ Date _____

Your "Eye Doctor's" Name _____

Your "Eye Doctor's" Address _____

Date of last exam or visit _____

Yes No At your last examination were you told you have any problems with your eyes?

Explain _____

Yes No Do you require glasses or contact lenses?

Yes No Have you had any injuries or surgery to the eyes or lids? (By whom?)

Explain _____

Yes No Are you bothered by frequent irritations or "allergies" of the eyes or lids?

Yes No Do you feel your eyes or lids swell excessively?

Yes No Do you now take or have you ever taken medications or drops for the eyes?

Explain _____

Yes No Are you bothered by "dry eyes"?

Yes No Do your eyes "water" or tear spontaneously (without emotional stimulation)?

Yes No Do you now have or have you ever had any visual problems with one or both eyes?

Explain _____

Yes No Are there any other problems we have not asked about that you feel we should know?

Explain _____

PLEASE READ THE FOLLOWING AND CARRY OUT THE INSTRUCTIONS:

Cover your RIGHT eye and read THIS sentence with your LEFT eye.

Are you able to read it comfortably?

without glasses with glasses

Cover your LEFT eye and read THIS sentence with your RIGHT eye.

Are you able to read it comfortably?

without glasses with glasses

If there is any difference in your vision please indicate:

Right eye stronger Left eye stronger Both eyes same (approximately)

I signify that to the best of my knowledge the information provided above is accurate.

Signed (patient) _____ Date _____