

**Getting Ready for Your Eye Exam at**

Holyoke Health Center Vision Center Disability Eye Care Services

267 High Street, Holyoke MA 01040-6585 P: 413-420-2825 F: 413-533-0472

|  |  |
| --- | --- |
| **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
 | * Your 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Thank you! We look forward to serving your eye care needs.**