PERKINS | VAN NATTA
SADOVE | KELLEY
MERIDIAN PLASTIC SURGERY CENTER

# *Patient Eye Information*

Name _____ Date _____

Your Eye Doctor's Name _____

Address _____ Date of last exam _____

***Yes*** ***No*** At your last exam, 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 to the eyes or eyelids?
Explain _____
_____

***Yes*** ***No*** Have you had any surgery to the eyes or eyelids? If so, who performed your surgery?
Explain _____
_____

***Yes*** ***No*** Do you feel your eyes or eyelids swell excessively?

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

***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 be aware of?
Explain _____
_____

***Please read the following and carry out the instructions:***

Cover your **Right** eye and read this sentence with your **Left** eye.

***Yes*** ***No*** Are you able to read it comfortably _____ without glasses?
_____ with glasses?

Cover your **Left** eye and read this sentence with your **Right** eye.

***Yes*** ***No*** Are you able to read it comfortably _____ without glasses?
_____ with glasses?

If there is any difference in your vision, please indicate which eye is stronger. _____Right eye _____ Left eye

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

Signed _____