# AESTHETIC SPECIALTY CENTRE

## EYE EVALUATION SHEET

**LEFT EYE**
OFFICE USE ONLY
No Glasses _______
Glasses __________

**RIGHT EYE**
OFFICE USE ONLY
No Glasses _______
Glasses __________

**By:**___________
**Date:**__________

**Name** ______________________________________________ **Date** _________________________

Your "Eye" Doctor's Name ____________________________________________________________

Telephone Number _________________________ Date of Last Exam ____________________

**PLEASE CIRCLE YES OR NO**

**Yes** **No** 1. At your last examination were you told that you have any problems with your eyes?
Explain__________________________________________________________________

**Yes** **No** 2. Do you require glasses or contact lenses?

**Yes** **No** 3. Have you had any injuries or surgery to the eyes or lids? (By whom?) ______________
Explain__________________________________________________________________

**Yes** **No** 4. Are you bothered by frequent "irritations" or "allergies" of the eyes or lids?

**Yes** **No** 5. Do you feel your eyes swell excessively?

**Yes** **No** 6. Do you now take or have you taken medications or drops for the eyes?
Explain__________________________________________________________________

**Yes** **No** 7. Are you bothered by "dry eyes?"

**Yes** **No** 8. Do your eyes "water" or tear spontaneously (without emotional stimulation?)

**Yes** **No** 9. Do you have or have you ever had any visual problems with one or both eyes?
Explain__________________________________________________________________

**Yes** **No** 10. Are there any other problems we have not asked about that you feel we should know?
Explain __________________________________________________________________

11. Cover your **RIGHT** eye and read **THIS** sentence with your **LEFT** eye.
Are you able to read it comfortably?

**Yes** **No** With glasses?

**Yes** **No** Without glasses?

12. Cover your **LEFT** eye and read **THIS** sentence with your **RIGHT** eye.
Are you able to read it comfortably?

**Yes** **No** With glasses?

**Yes** **No** Without glasses?

**Yes** **No** 13. Is there any difference in your vision?
Right eye stronger? _____ Left eye stronger? _____ Both eyes the same? _____

Patient signature: ________________________________________ Date: _____________________