EASTERN COSMETIC SURGERY INSTITUTE

Timothy M. Greco, M.D., P.C.

EYE EVALUATION SHEET

Your Name _____ Date_____

Your "Eye Doctor's" Name & Address _____

_____

☐No ☐Yes 1. At your last examination were you told you have problems with your eyes?

Explain_____

☐No ☐Yes 2. Do you require glasses or contact lenses? (Circle which)

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

Explain_____

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

Explain_____

☐No ☐Yes 5. Do you feel your eyes or lids swell excessively?

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

Explain _____

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

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

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

Explain_____

☐No ☐Yes 10. Are there any other problems we have no asked about that you feel we should know?

Explain_____

☐No ☐Yes 11. Do you have a history of **Glaucoma** (increased pressure in the eyes)

If so what drops do you take for **Glaucoma?** _____

OVER ▶

PLEASE READ THE FOLLOWING AND CARRY OUT THE INTRUCTIONS:

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

   ☐No ☐Yes Are you able to read it comfortably?

   ____ with glasses _____ without glasses.

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

   ☐No ☐Yes Are you able to read it comfortably?

   ____ with glasses ____ without glasses.

   If there is a 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:_____