Date: _____

Name: _____

EYE EXAMINATION QUESTIONNAIRE

Please tell us the reason of your visit today:

Eyelids Eyelid lesions Thyroid disease Other: _____

Lazy eyes Turning eyes Eye exam

How were you referred to us (please specify physician / school nurse / person / doctor)?

If so, who? _____

Please list any medications you are taking at this time, including eye drops: _____

_____

Please list any known allergies to medications: _____

Please list any past surgeries: _____

Is there a chance you may be pregnant? _____

Please list any medical history: _____

Please list any eye history: _____

Please list any family history: _____

Social History

Alcohol use: _____

Smoking: _____

Recreational drug use: _____

Occupation: _____

With whom do you live? _____

Education: _____

(Please continue on reverse side)

Date: _____

Name: _____

Circle any of the following areas which you may be interested in improving:

Drooping eyelids
Hollowing in lower eyelids
Lines between eyes (angry look)
Crease nose to corner of mouth
Lines around lips
Puffy eyelids
Excess eyelid skin
Thin face, hollow cheeks
Removal of moles, bumps or skin tags
Looking "tired"
Lines under and around eyes
Frown on the corner of mouth
Thin lips
Dark circles under eyes

Circle any of the following products/treatments you may be interested in:

Botox
Restylane
Juvederm
Perlane
Medical grade skin creams
Laser skin resurfacing
Browlift surgery
Eyelid surgery