SMITH COSMETIC SURGERY
25 Years of Artistic Excellence
BRENT J. SMITH, MD

Eye Evaluation Information

Patient Name_____ Date of last eye exam_____

No Yes 1. Do you wear glasses or contact lenses? (**Please circle one**)

No Yes 2. Have you had any injuries or surgery to your eye lids?

If yes, please explain: _____

No Yes 3. Do you have frequent irritations to the eyes or lids?

No Yes 4. Do you now take or have you taken medications or drops for your eyes?

No Yes 5. Are you bothered by 'dry eyes?"

No Yes 6. Do you eyes tear excessively?

No Yes 7. Do you now have or have you ever had visual problems with one or both eyes?

No Yes 8. Are there any other problems we have not asked about which you feel we should know?

Please read the following instructions and answer the questions:

No Yes 1. Cover your RIGHT eye and read THIS sentence with your LEFT eye only.

Are you able to read it comfortably?

_____ with glasses? _____without glasses?

No Yes 2. Cover your LEFT eye and read THIS sentence with your RIGHT eye only.

Are you able to read it comfortably?

_____with glasses? _____without glasses?

If there is any difference in your vision, please indicate:

___Both eyes are the same (approximately)

___Right Eye Stronger

___Left Eye Stronger

I attest that the information provided above is correct to the best of my knowledge.

_____ _____

Patient/Legal Guardian Date