

### Instructions:

Open with Adobe Acrobat Reader. Click in each box. Fill in all information. Print.

### Your Eye Health

Name:

Birthdate (month/day/year) :

Optometrist Name:

Phone:

Date of last exam:

Eye Conditions/Diagnosis:

Eyeglass Prescription:

Date Purchased:

Eyeglass Store:

Phone :

Ophthalmologist Name:

Phone:

Eye Conditions/Diagnosis:

### Family Eye Health

Please use the following area to record eye health conditions that may run in your family and/or relatives. This information may be helpful for early detection during regular eye check ups. Circle the answer that applies.

Eye Conditions Present in Family Relative(s):  Yes  No

Macular Degeneration:  Yes  No

Cataracts:  Yes  No

Glaucoma:  Yes  No

Droopy Eyelids:  Yes  No