Adult & Pediatric Otolaryngology
Head & Neck Surgery
Facial Plastic Surgery
Endoscopic Sinus Surgery
Neurotology
Skull Base Surgery
Reconstructive Surgery
LASER Surgery
Nasal Allergy
Clinical Audiology
Hearing Aid Dispensing
Voice Care

The Ear, Nose, Throat & Plastic Surgery Associates

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Henry N. Ho, M.D., F.A.C.S.
Jeffrey J. Lehman, M.D., F.A.C.S.
Izak H. Kielmovitch, M.D., F.A.C.S., F.A.A.P.
Jeffrey E. Baylor, M.D., F.A.C.S.
Kiran Tipirneni, M.D., F.A.C.S.
Brian C. Spector, M.D., F.A.C.S.
Aftab H. Patni, M.D., F.A.C.S.
Hao N. Tran, M.D., F.A.C.S.
Barry S. Kang, M.D, F.A.C.S.
Halla F. Shami, M.D. F.A.C.S.
Christopher R. Savage, M.D.
Leela S. Lavasani, M.D.
Jeffrey S. Fichera, M.S., PA-C
Jessica E. Curley, M.S., PA-C

EYE EVALUATION (BLEHPAROPLASTY) SHEET

Name: _____ (Please print name)

Date of last eye examination: _____

Name of Eye Doctor who performed the exam: _____
Address of Eye Doctor: _____
_____

Please circle Yes or No to the following questions:

Yes **No** Do you wear glasses or contact lenses?
Yes **No** Have you had any surgeries or injuries to your eyes or lids?
If yes, please explain: _____
Yes **No** Are you taking or have you taken medications or drops for your eyes?
If yes, please explain: _____
Yes **No** Are you bothered by "dry eyes"?
Yes **No** Do your eyes tear excessively?
Yes **No** Are you having or ever had visual problems with one or both eyes?
If yes, please explain: _____
Yes **No** Do you have any other problems with your eyes that we should know about?
If yes, please explain: _____

Please read and follow the instructions for each sentence.

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

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
____ Right eye is stronger
____ Left eye is stronger

I have provided the above information to the best of my knowledge and ability.

Patient Signature: _____ Date: _____

9/7/12

133 Benmore Drive, Suite 100
Winter Park, FL 32792-4111
TEL: 407-644-4883
FAX: 407-644-3697

107 The Hermits Trail
Altamonte Springs, FL 32701-3619
TEL: 407-834-9120
FAX: 407-834-3432

44 W. Michigan Street
Orlando, FL 32806-4453
TEL: 407-422-4921
FAX: 407-839-1746

400 Celebration Place, Suite A120
Celebration, FL 34747-4970
TEL: 407-422-4921
FAX: 407-839-1746