

## BLEPHAROPLASTY PRE-OP QUESTIONNAIRE

Date of your examination: \_\_\_\_\_

Doctor's name, address, who performed the exam: \_\_\_\_\_

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1. Do you wear glasses or contact lenses? (circle which) NO YES
2. Have you had any injuries or surgery to the eyes or lids? (circle which) NO YES
3. Do you have frequent irritations to the eyes or lids? (circle which) NO YES
4. Do you now take or have you taken medications or drops for the eyes? (circle which) NO YES
5. Are you bothered by "dry eyes"? (circle which) NO YES
6. Do your eyes tear excessively? (circle which) NO YES
7. Do you now have or have you ever had visual problems with one or both eyes? (circle which) NO YES
8. Are there any other problems we have not asked about that you feel we should know? (circle which) NO YES

**Please read the following and carry out the instructions:**

1. Cover your RIGHT eye and read THIS sentence with your LEFT eye only. Are you able to read it comfortably? (circle which) NO YES
2. Cover your LEFT eye and read THIS sentence with your RIGHT eye only. Are you able to read it comfortably? (circle which) NO YES  
\_\_\_\_\_ with glasses. \_\_\_\_\_ without glasses.

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

Both eyes same (approximately \_\_\_\_\_)

Right eye stronger \_\_\_\_\_

Left eye stronger \_\_\_\_\_

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

Patient Signature: \_\_\_\_\_