

About me and my eyes

Please bring these things to your eye test:

- Your glasses
- Your prescription from your last eye test
- Your Health Action Plan or Hospital Passport

My full name:

Today's date:

My details

Address and postcode:

Phone number:

Email address (if you have one):

Date of birth:

Ethnicity:

Name of GP

GP address

Details of my carer or supporter

Full name:

Address and postcode:

Phone number:

Email address:

Relationship to me:

Eye care history: Visits to the optician or optometrist

Have you ever had an eye test at the opticians or optometrists?

Yes

No

Don't know

If you put no or don't know, go to the next section on your visits to the hospital.

If yes, name and address of most recent opticians and optometrists:

Date of your last eye test before this one:
(SeeAbility recommends an annual eye test)

Did you have your eye pressure tested at your last eye test?

Yes

No

Don't know

Results:

Eye care history: Visits to the hospital

Have you ever been to the eye clinic in a hospital?



Yes

No

Don't know

If you put no or don't know, go to the next section on your glasses.

If yes, what was the problem?

Name of the hospital you went to:

Date of your **last** appointment:

Date of your **next** appointment:

Did you have an operation on your eyes?

Yes

No

Don't know

If yes, what operation did you have on your eyes?

Glasses

Have you been prescribed glasses either by an optician or optometrist or from the eye clinic at a hospital?



Yes

No

Don't know

If you put no or don't know, go to the next section on other eye information.

Are you wearing your glasses?

Yes

No

Don't know

Do you have any problems with your glasses?

Yes

No

Don't know

If yes, please tell us what they are:

Other eye information

Are you registered blind or severely sight impaired?



Yes

No

Don't know

Are you registered partially sighted or sight impaired?

Yes

No

Don't know

Do your eyes always appear straight?

Yes

No

Sometimes

Don't know

Do your eyes appear to move very quickly or uncontrollably?

Yes

No

Don't know

Do you have trouble controlling your eye movements?

Yes

No

Don't know

If yes, please give us more details:

Do you often shut one eye?

Yes

No

Don't know

Are you sensitive to bright lights?



Yes

No

Don't know

Do you get headaches or eye pain?

Yes

No

Don't know

Do you generally have worries about your eyes?

Yes

No

Don't know

If yes, please give tell us what they are:

Other health information

Do you use a wheelchair?



Yes

No

Don't know

Do you have any health problems or disabilities?

Yes

No

Don't know

If yes, please let us know what they are:

Do you take any medication?

Yes

No

Don't know

If yes, please tell us here:

(Please take information about the medication to the eye test)

Do you have any allergies?

Yes

No

Don't know

If yes, please tell us what they are:

Eye information about your family

Has anyone in your family had eye problems?

Yes

No

Don't know

For example, does anyone have glaucoma, diabetes or an eye condition?

If yes, please tell us which family member had the problem and what the problem was?

The eye test

When you have your eye test, the optician will need to:

- look at your eyes.
- do some tests to check how well you can see.

The information you give below will help us to test your eyes.

Will you be okay if the optometrist comes close to you and shines a bright light in your eyes?

Yes

No

Don't know



This is done with an instrument called an ophthalmoscope.

Will you be okay if the optometrist covers one of your eyes?

Yes

No

Don't know

Can you understand if you can see something better or worse?



Yes

No

Don't know

Will you be able to wear test glasses on your face?



Yes

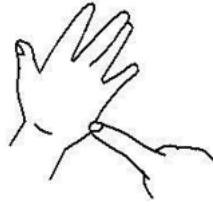
No

Don't know

Can you say or sign the names of **letters** on an eye test chart?



← T →

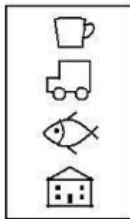


Yes

No

Don't know

Can you say or sign the names of **pictures** on a chart (like house, fish, car)?



← HOUSE →

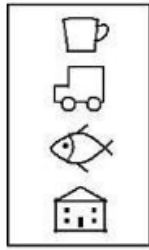


Yes

No

Don't know

Can you point to a **letter** or **picture** on a card that is the same letter or picture on a chart on the wall?



Yes

No

Don't know

Are you deaf or hard of hearing?

Yes

No

Don't know

If yes, please tell us more details:

Do you use any of the methods below to communicate?
Please also tell us any other ways you communicate with people.

Makaton

Yes

No

An interpreter

Yes

No

Pictures or PECS

Yes

No

Gestures

Yes

No

Other ways you communicate:

Is there any other information about you we need to know?

**Thank you for sharing information about your eyes.
This will help you get the eye care you need.**



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