DR. DANIEL MOTTOLA
OPTOMETRY • OPHTHALMIC MEDICINE

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Vision Correction History

Review draft

Please print clearly.

PATIENT INFORMATION

Name

EYE CONDITIONS

Select any that apply to you. Explain if appropriate.

- ☐ **Crossed Eyes**
- ☐ **Lazy Eye**
- ☐ **Drooping eyelid**
- ☐ **Prominent Eye**

GLASSES

Do you wear glasses? ☐ Yes ☐ No If yes, for how long

If yes, how are near and distance vision with glasses?
Near

Distance

CONTACTS

Do you wear contacts? ☐ Yes ☐ No If yes, for how long

If no, have you ever tried?