Washington-Greene County Blind Association
566 East Maiden Street, Washington PA 15301
(724) 228-0770 (724) 228-6617 Fax washgreene@onecommail.com

Adult Vision Screening (Glaucoma) Consent Form

Name: _____ Sex: ( ) M ( ) F
Last First

Address: _____
Street City State Zip code

Phone: ( ) _____ Birth date: _____

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- Are you presently under care for: ( ) Glaucoma ( ) Diabetes ( ) Heart Condition ( ) Other: _____
- If you are diabetic, when were you diagnosed? _____
  Do you take insulin? ( ) Yes ( ) No
- Do any of your immediate family members have glaucoma? ( ) Yes ( ) No
- Are you wearing contact lenses? ( ) Yes ( ) No
- Are you having any new eye problems at present? ( ) Yes ( ) No If yes, please describe: _____
- What is your eye doctor's name? _____
- When was your last complete eye examination? _____

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This procedure is a limited screening designed only to detect higher than normal intraocular pressure - one of the symptoms of glaucoma. It is NOT intended to diagnose glaucoma, nor will it reveal symptoms of other eye diseases. It is recommended that all persons over the age of 35 have their eyes checked by a professional eye doctor at least every two years. Persons having a family history of glaucoma, regardless of age, should have an eye examination annually.

Signature: _____ Date: _____

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Visual Acuity - Without glasses With glasses **Amsler Grid** **Intraocular Pressure**

Distance OD _____ OS _____ OD _____

Near OU _____ OS _____

Referred _____ **Reason** _____

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