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PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Sex at Birth: ☐ Male ☐ Female

Phone Number: ( ) _____ - _____

Home Address: _____

PATIENT HISTORY

Were you referred to our office? ☐ Yes ☐ No

If yes, by whom? _____

Chief Complaint / Reason for Visit:

_____

When did you notice the problem? _____

Has the problem become: ☐ Better ☐ Worse ☐ Stayed the Same

Has there been any previous treatment? ☐ Yes ☐ No

If yes, please describe:

_____

ADDITIONAL TESTING HISTORY – Please select all that apply and summarize the results.

☐ Educational ☐ Hearing ☐ Neurological ☐ Psychological

☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy ☐ Chiropractor

_____

_____

_____

PATIENT MEDICAL HISTORY

Primary Care Doctor: _____

Last Visit Date: _____ Reason for Visit: _____

Have you been diagnosed with or treated for the following health problems?
If yes, please describe:

- ☐ Cancer: _____
- ☐ Digestive / Gastrointestinal: _____
- ☐ Ear / Nose / Throat: _____
- ☐ Genitourinary: _____
- ☐ Neuro / Traumatic Brain Injury: _____
- ☐ Muscle / Bone / Arthritis: _____
- ☐ Psych / Behavioral: _____
- ☐ Skin Condition / Disorders: _____
- ☐ High Blood Pressure / Cholesterol: _____
- ☐ Diabetes / Thyroid / Endocrine: _____
- ☐ Respiratory / Asthma: _____
- ☐ Immune / Allergies: _____

Are you taking any medications? ☐ Yes ☐ No

If yes, which medications and what dosage?

_____

Do you have any known allergies? ☐ Yes ☐ No

If yes, please list the allergy and reaction?

_____

Have you had any adverse reactions to immunizations? ☐ Yes ☐ No

If yes, which immunization and what was the reaction?

_____

FAMILY HISTORY

Does anyone in your family have any of the following conditions. If yes, who?

- ☐ Cancer: _____
- ☐ Diabetes: _____
- ☐ Hypertension: _____
- ☐ Hyperthyroidism: _____
- ☐ Hypothyroidism: _____
- ☐ Cataracts: _____
- ☐ Macular Degeneration: _____
- ☐ Glaucoma: _____

SOCIAL HISTORY

Do you use tobacco? ☐ Yes ☐ No If yes, for how long? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, for how long? _____

Do you have a care giver? ☐ Yes ☐ No If yes, who? _____

BRAIN INJURY HISTORY

Have you sustained a brain injury? ☐ Yes ☐ No If yes, when? _____

How did the injury happen? _____

What other treatment(s) have you received for your brain injury?

_____

VISUAL HISTORY

Date of last eye examination: _____ Doctor's Name: _____

Were you prescribed: ☐ Glasses ☐ Contacts

Prescribed for: ☐ Full-Time Wear ☐ Distance Only ☐ Near Only

Have the following vision problems been diagnosed?

Amblyopia (Lazy Eye): ☐ Yes ☐ No

If yes, have you received treatment: _____

Strabismus (Eye Turn): ☐ Yes ☐ No

If yes, have you received treatment: _____

Which eye turns: ☐ Left Eye ☐ Right Eye ☐ Both Eyes

Did the eye turn start: ☐ Suddenly ☐ Gradually

Which direction does the eye turn: ☐ In ☐ Out ☐ Up ☐ Down

Vision Symptom Survey

Please complete the following checklist to help us evaluate your visual symptoms.

	NEVER (1)	SELDOM (2)	OCCASIONALLY (3)	FREQUENTLY (4)	ALWAYS (5)
EYESIGHT CLARITY					
Distance vision blurred and no clear – even with lenses	☐	☐	☐	☐	☐
Near vision blurred and no clear – even with lenses	☐	☐	☐	☐	☐
Clarity of vision changes or fluctuates during the day	☐	☐	☐	☐	☐
Poor night vision / can't see well to drive at night	☐	☐	☐	☐	☐
VISUAL COMFORT					
Eye discomfort / sore eyes / eyestrain	☐	☐	☐	☐	☐
Headaches or dizziness after using eyes	☐	☐	☐	☐	☐
Eye fatigue / very tired after using eyes all day	☐	☐	☐	☐	☐
Feel "pulling" around the eyes	☐	☐	☐	☐	☐
DOUBLING					
Double Vision – especially when tired	☐	☐	☐	☐	☐
Have to close or cover one eye to see clearly	☐	☐	☐	☐	☐
Print moves in and out of focus when reading	☐	☐	☐	☐	☐
LIGHT SENSITIVITY					
Normal Indoor lighting is uncomfortable – too much glare	☐	☐	☐	☐	☐
Outdoor light too bright – have to use sunglasses	☐	☐	☐	☐	☐
Indoors fluorescent lighting is bothersome or annoying	☐	☐	☐	☐	☐
DRY EYES					
Eyes feel "dry" and sting	☐	☐	☐	☐	☐
"Stare" into space without blinking	☐	☐	☐	☐	☐
Have to rub the eyes a lot	☐	☐	☐	☐	☐
DEPTH PERCEPTION					
Clumsiness / misjudge where objects really are	☐	☐	☐	☐	☐
Lack of confidence walking / missing steps / stumbling	☐	☐	☐	☐	☐
Poor handwriting (spacing, size, legibility)	☐	☐	☐	☐	☐

Vision Symptom Survey Continued

Please complete the following checklist to help us evaluate your visual symptoms.

	NEVER (1)	SELDOM (2)	OCCASIONALLY (3)	FREQUENTLY (4)	ALWAYS (5)
PERIPHERAL VISION					
Side vision distorted / objects move or change position	☐	☐	☐	☐	☐
What looks straight ahead--isn't always straight ahead	☐	☐	☐	☐	☐
Avoid crowds / can't tolerate "visually-busy" places	☐	☐	☐	☐	☐
READING					
Short attention span / easily distracted when reading	☐	☐	☐	☐	☐
Difficulty / slowness with reading and writing	☐	☐	☐	☐	☐
Poor reading comprehension / can't remember what was read	☐	☐	☐	☐	☐
Confusion of words / skip words during reading	☐	☐	☐	☐	☐
Lose place / have to use finger not to lose place when reading	☐	☐	☐	☐	☐