# ADULT VISION QUESTIONNAIRE / HEAD TRAUMA HISTORY

***Please fill out this questionnaire carefully.***

***Please bring the completed form with you on the day of the evaluation. Thank you!***

**GENERAL INFORMATION:** Today's Date:____________

Patient's Full Name:_____________________________________ Age______ Birth Date__________ M____ F____

Spouse/Significant Other: ______________________________________________________________________________

Were you referred to our office? Yes______ No______

If yes, whom may we thank for this referral? Name__________________________________________________________

Phone: ______________________________ Fax:_____________________________________

**VISUAL HISTORY:**

What is the main reason for today's vision exam?___________________________________________________

___________________________________________________________________________________________

How long has this problem/difficulty been observed?________________________________________________

___________________________________________________________________________________________

Has there been a recent vision exam? Yes______ No_______

If yes, Date:______________________ Name of Doctor: ____________________________________________

Results and recommendations:_________________________________________________________________

___________________________________________________________________________________________

Are glasses or contacts worn? (please circle all that apply) If so, how often?____________________________________

*Contact Prescription: (or please bring a copy of your prescription from your optometrist, **this will be needed for exam**)

R – brand__________________ base curve __________ diameter ___________ sphere_________

L – brand__________________ base curve __________ diameter ___________ sphere_________

*Glasses Prescription: (or please bring a copy of your prescription from your optometrist, **this will be needed for exam**)

R – Sphere ___________ Cylinder _____________ Axis______________ Add________________ Prism? Vert/Hori _____

L – Sphere ___________ Cylinder _____________ Axis______________ Add________________ Prism? Vert/Hori _____

Have the following vision problems been diagnosed?

Amblyopia (lazy eye)________ If so, when were you diagnosed?___________ Treatment? ________________________

Strabismus (eye turn)________ If so, when were you diagnosed?___________ Treatment? ________________________

**VISUAL SYMPTOM SURVEY – Please complete all**

Please rank each of the following symptoms. 0= Never, 1= Seldom, 2= Occasionally, 3= Frequently, 4= Always

| Symptoms | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| Blur when looking at near | | | | | |
| Double Vision | | | | | |
| Headaches with near work | | | | | |
| Words run together when reading | | | | | |
| Burning, stinging, watery eyes when reading | | | | | |
| Falls asleep when reading | | | | | |
| Vision worse at the end of the day | | | | | |
| Skips/repeats lines when reading | | | | | |
| Dizzy/Nauseous with near work | | | | | |
| Tilts head or closes one eye when reading | | | | | |
| Difficulty copying from far to near | | | | | |
| Reversal of letters like b's, d's, p's and q's | | | | | |
| Avoids near work/reading | | | | | |
| Omits small words when reading | | | | | |
| Writes up/down hill | | | | | |
| Misaligns digits/columns of numbers | | | | | |
| Reading comprehension declines over time | | | | | |
| Poor/inconsistent in sports | | | | | |
| Holds reading material too close | | | | | |
| Short attention span | | | | | |
| Difficulty completing assignments on time | | | | | |
| Says "I can't" before trying | | | | | |
| Avoids sports/games | | | | | |
| Poor eye-hand coordination | | | | | |
| Does not judge distance accurately | | | | | |
| Clumsy, knocks things over | | | | | |
| Loses belongings/things | | | | | |
| Car/motion sickness | | | | | |
| Forgetful/poor memory | | | | | |
| Sensitive to lighting (too light/too dark) | | | | | |
| Poor Handwriting | | | | | |
| **Totals (office use only)** | | | | | |

List any other vision related concerns: ____________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

**EDUCATION/EMPLOYMENT INFORMATION**:

Current status: _____Full Time Student _____Part Time Student _____Full Time Employment

_____ Part Time Employment _____Retired

How many hours do you use a computer in your work, school, or leisure activities each day? ______________

How many hours do you read printed material each day? ________________________________________

Do you wear glasses or contacts while at the computer? Yes________ No________

How do your eyes feel after working at the computer? ____________________________________________

Please list any specific tasks that you find challenging in your current situation: _________________________

____________________________________________________________________________________________
_____________________________________________________________________________

**MEDICAL HISTORY**:

Primary Care Doctors Name: ________________________________________________________________

Address: _____________________________________________________________________________

____________________________________________________________________________________

Phone: ___________________________________ Fax:_______________________________________

Would you like a report sent to this doctor? Yes______ No_______

Are you pregnant? Yes____ No_____ Are you nursing? Yes_____ No______

Medications: (including any vitamins, supplements and reason for taking)

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Any medication allergies? Yes______ No______

If yes, name of medication:_________________________________ Reaction: ____________________________

List any significant illnesses, head injury, surgical procedures, etc.:

Date of Injury Complications

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Any chronic health problems like asthma, hay fever, allergies, etc.? Yes______ No_______

If yes, please explain,___________________________________________________________________

Do you have problems now or previously in the following areas:

| **Condition** | **Circle one** | **If so, please explain** |
|---|---|---|
| Smoking | Y or N | |
| Cancer | Y or N | |
| Weight loss/gain | Y or N | |
| Skin | Y or N | |
| Allergies | Y or N | |
| Neurological | Y or N | |
| Ear/Nose/Throat | Y or N | |
| Psychological | Y or N | |
| Endocrine/Hormone | Y or N | |
| Diabetes | Y or N | When were you diagnosed? |
| Heart or Vascular | Y or N | |
| Blood | Y or N | |
| Gastrointestinal | Y or N | |
| Kidney | Y or N | |
| Bladder | Y or N | |
| Muscle Pain | Y or N | |
| Joint Pain | Y or N | |
| Autoimmune disease | Y or N | |
| Infectious Disease (HIV, Hepatitis, etc) | Y or N | |
| Other | Y or N | |

FAMILY HISTORY:

Has anyone in your immediate family had or currently have any problems in the following areas:

| **Condition** | **Circle one** | **Who?** | **Condition** | **Circle one** | **Who?** |
|---|---|---|---|---|---|
| Diabetes | Y or N | | Blindness | Y or N | |
| Heart Disease | Y or N | | Macular Degeneration | Y or N | |
| High Blood Pressure | Y or N | | Strabismus (eye turn) | Y or N | |
| Kidney Disease | Y or N | | Amblyopia (lazy eye) | Y or N | |
| Thyroid Disease | Y or N | | Glaucoma | Y or N | |
| Cancer | Y or N | | Retinal Detachment | Y or N | |
| Rheumatoid Arthritis | Y or N | | Learning Disability | Y or N | |
| Other | Y or N | | | | |

**SPECIAL TESTING:**

Has a neurological evaluation been performed? Yes_____ No_____ If so, by whom? ____________________________

Results and Recommendations:_____________________________________________________________________________

_________________________________________________________________________________________________________

Has a psychological evaluation been performed? Yes____ No____ If so, by whom? ______________________________

Results and Recommendations:_____________________________________________________________________________

_________________________________________________________________________________________________________

Has an occupational therapy evaluation been performed? Yes____ No____ If so, by whom?________________________

Results and Recommendations:_____________________________________________________________________________

_________________________________________________________________________________________________________

Has a physical therapy evaluation been performed? Yes____ No____ If so, by whom?_____________________________

Results and Recommendations:______________________________________________________________________

__________________________________________________________________________________________________

Has a speech/hearing evaluation been performed? Yes____ No____ If so, by whom?____________________

Results and Recommendations:______________________________________________________________________

__________________________________________________________________________________________________

Has educational testing been performed? Yes____ No____ If so, by whom? ___________________________

Results and Recommendations:______________________________________________________________________

__________________________________________________________________________________________________

**LEISURE TIME ACTIVITIES**:

Do you like to read? Yes____ No____ Do you read for pleasure? Yes____ No____

List any hobbies or sports: __________________________________________________________________________

_________________________________________________________________________________________________________

Are there activities you would like to participate in, but don’t? _________________________________________

_________________________________________________________________________________________________________

Give a brief description of yourself as a person: ______________________________________________________

_________________________________________________________________________________________________________

_________________________________________________________________________________________________________