river view
FAMILY EYECARE

OREGON
VISION DEVELOPMENT CENTER

# ADULT VISION QUESTIONNAIRE

***Please fill out all sections of this questionnaire carefully (IT IS DOUBLE SIDED) and bring it with you to the evaluation.***

## GENERAL INFORMATION

Full Legal Name: _____ Everyday Name: _____

Sex: □Male □Female □Other _____ Gender (if different): _____ Pronoun: _____

Birthdate: _____ Age: _____ Email Address: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____

Were you referred to our office? Yes □ No □ By whom? _____

## INSURANCE FILING

If you have major medical insurance, please provide information for the Primary Insured:

Name of Insured: _____ Relationship to Insured: _____

Birth Date: _____ Employer: _____

Social Security Number: _____ Driver's License Number: _____

## MEDICAL HISTORY

Date of most recent evaluation: _____ Physician's Name: _____

For what problem/condition? _____

Results and recommendations: _____

Medications currently using, including vitamins and supplements: _____

_____

For what condition(s)? _____

Do you have any allergies? Yes □ No □ If yes, please list: _____

Current diet: Excellent □ Good □ Fair □ Poor □

List illnesses, bad falls, high fevers, concussions, etc.:

| Age | Severity | Complications |
|---|---|---|
| | | |
| | | |
| | | |

Are you generally healthy? Yes □ No □

If no, explain: _____

Has a neurological evaluation been performed? Yes □ No □

By whom? _____ Results/recommendations: _____

Has a psychological evaluation been performed? Yes □ No □

By whom? _____ Results/recommendations: _____

Has an occupational therapy evaluation been performed? Yes □ No □

By whom? _____ Results/recommendations: _____

Is there any history of the following?

| | Patient | Family | Who | | Patient | Family | Who |
|---|---|---|---|---|---|---|---|
| Diabetes | □ | □ | _____ | High Blood Pressure | □ | □ | _____ |
| Multiple Sclerosis | □ | □ | _____ | Thyroid condition | □ | □ | _____ |
| Blindness | □ | □ | _____ | Cataracts | □ | □ | _____ |
| Glaucoma | □ | □ | _____ | Brain Tumor | □ | □ | _____ |

**VISUAL HISTORY**

Has you had a previous vision evaluation? Yes □ No □

Doctor's Name: _____ Date of Last Visit: _____

Reason for examination: _____

Results and recommendations: _____

Were glasses, contact lenses, or other optical devices prescribed or recommended? Yes □ No □

If so, what? _____

Do you use them? Yes □ No □

How long have you had glasses and/or contact lenses? _____

If used, when? _____ If not, why not? _____

Have you ever been told that you have amblyopia ("lazy eye")? Yes □ No □

Have you ever been told that you have strabismus ("wondering eye")? Yes □ No □

Has there been any treatment using an eye patch? Yes □ No □

If yes, please describe when the patching was started, how the patching was done, including the age it started, the eye patched, the duration of treatment, and an estimate of the results: _____

_____

Has there been any surgical treatment? Yes □ No □

If yes, please describe the surgery, including the age surgery was performed, the number of operations, the eye (s) operated on, and an estimate of the cosmetic and subjective results: _____

_____

**PRESENT SITUATION**

Why do you feel the need for a visual evaluation? _____

_____

How long has this problem/difficulty existed? _____

Please answer the following questions about how your eyes feel when reading or doing close work.

| | | Never | Infrequently (not very often) | Sometimes | Fairly often | Always |
|---|---|---|---|---|---|---|
| 1. | Do your eyes feel tired when reading or doing close work? | | | | | |
| 2. | Do your eyes feel uncomfortable when reading or doing close work? | | | | | |
| 3. | Do you have headaches when reading or doing close work? | | | | | |
| 4. | Do you feel sleepy when reading or doing close work? | | | | | |
| 5. | Do you lose concentration when reading or doing close work? | | | | | |
| 6. | Do you have trouble remembering what you have read? | | | | | |
| 7. | Do you have double vision when reading or doing close work? | | | | | |
| 8. | Do you see the words move, jump, swim or appear to float on the page when reading or doing close work? | | | | | |
| 9. | Do you feel like you read slowly? | | | | | |
| 10 | Do your eyes ever hurt when reading or doing close work? | | | | | |
| 11. | Do your eyes ever feel sore when reading or doing close work? | | | | | |
| 12. | Do you feel a "pulling" feeling around your eyes when reading or doing close work? | | | | | |
| 13. | Do you notice the words blurring or coming in and out of focus when reading or doing close work? | | | | | |
| 14. | Do you lose your place while reading or doing close work? | | | | | |
| 15. | Do you have to re-read the same line of words when reading? | | | | | |
| | | ___x0 | ___x1 | ___x2 | ___x3 | ___x4 |
| | | | | | Total Score | |

| In addition, do you experience any of the following: | | | | | |
|---|---|---|---|---|---|
| Blurred vision at distance | | Blurred vision at near | | Confusion of what is being seen or read | |
| Double vision at distance | | Double vision at near | | Silent vocalization / moving lips when reading | |
| Head tilt to improve vision | | | | Difficulty aligning columns of numbers | |
| Squinting, covering, or closing one eye | | | | Can respond better orally than in writing | |
| Postural changes when doing desk work | | | | Poor handwriting | |
| When reading, need very bright light | | dim light | | Poor time management | |
| Loss of interest or short attention span for close work | | | | Inconsistent performance in work or sports | |
| Difficulty sustaining reading / writing | | | | Poor general coordination | |
| General of visual fatigue at the end of the day | | | | Poor fine motor coordination | |
| Skip lines when reading | | | | Difficulties with short-term memory | |
| Repetition of letter or words when reading | | | | Difficulties with long-term memory | |
| Omission of words when reading / copying | | | | Nausea associated with visual tasks * | |
| Head moves when reading | | | | Motion / car sickness* | |
| * if you answered yes, please complete the *Dizziness and Motion Sensitivity Checklist* | | | | | |

Comments on any items above: _____

_____

_____

**DIZZINESS AND MOTION SENSITIVITY CHECKLIST**

□ Nausea, headache or dizziness when reading in the care even on a STRAIGHT road
□ Nausea, headache or dizziness when sitting close to a movie screen or watching a train go by
□ Hyper sensitive to light (store lights seem to bright, tend to wear sunglasses even on cloudy days)
□ Frequent, sometimes daily, headache or "pressure" in your head
□ Nausea, headache or dizziness or spacey feeling when shopping or moving through crowds of people
□ Unusual fear of heights
□ Flickering lights bother you (light through trees when driving or fluorescents)
□ Avoidance of driving (or being a passenger) because of car sickness

**EMPLOYMENT OR SCHOOL**

Current position: _____
Briefly describe your daily activities at work or in school: _____

_____

How many hours daily to you:

spend at a desk? _____ reading or studying? _____ working at near distances? _____

Do you feel you are achieving to your potential in work or school? Yes □ No □
Do you feel you are getting adequate return for the amount of effort you put into a task? Yes □ No □

If no, please explain: _____

Does your work or course of study demand comprehension from the written word? Yes □ No □

**COMPUTER / TELEVISION VIEWING / LEISURE TIME ACTIVITIES**

Do you use a computer in your work, school, or leisure time activities? Yes □ No □
How many hours each day do you spend in front of a computer? _____
Do you watch TV? Yes □ No □ How many hours per day? _____ Per week? _____
How many hours each day do you spend on additional screens (tablet, phone, etc)? _____
Do you wear specific glasses, contact lenses, or other optical devices for computer work? Yes □ No □

If yes, please explain: _____

Where is the top of your computer screen located (above, at, below eye level)? _____
What is the distance from: your eyes to the screen?_____ to the keyboard? _____ to your documents? _____
Please describe any problems you have with your vision, current glasses or contact lenses for computer work:

_____ _____

Are you involved with athletics? Yes □ No □

Do you feel you are achieving up to your potential in sports / athletics? Yes □ No □

Describe the types of activities that comprise most of your leisure time: _____

_____

**RELEASE OF INFORMTATION AND INSURANCE FILING**

**It is often beneficial for us to discuss examination results and to exchange information with other professionals involved in your care. Please sign below to authorize the release of information. You will be notified when information is exchanged.**

I agree to permit information from, or copies of, my examination records to be exchanged with other health care providers or provided to insurance carriers upon their written request or upon the recommendation of River View Family Eyecare and the Oregon Vision Development Center when it is necessary for the treatment of my visual condition or for the processing of insurance claims. This authorization shall be considered valid throughout the duration of treatment.

_____ _____

Signature or Authorized Representative Date

****

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation related to your specific visual needs.

Please be on time for your examination so that we will have the maximum opportunity to evaluate your child's visual status.