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: ___________________________

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 □ Sleep: Excellent □ Good □ Fair □ Poor □

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

Have 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: ____

____

BRAIN TRAUMA HISTORY

Date of most recent event: ________________________

Briefly describe the injury: ____

____

What part of the head was affected?

□ Forehead □ Right side □ Left side □ Back of head □ Top of head □ Face

Was there a loss of consciousness? Yes □ No □ For how long? ______________________________________

When did you first see a doctor regarding your accident / injury? _______________________________________

Were you hospitalized? Yes □ No □

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: _______________________________

List additional professional care you have received or are receiving care from due to this injury?
(Such as physical therapy, speech therapy, auditory therapy, cognitive therapy, chiropractic, osteopathic, acupuncture, cranio-sacral, neurofeedback, massage)

____

____

____

Describe any previous injuries and dates:

____

____

Currently, what is your most significant visual concern?

____

Are you experiencing headaches? Yes □ No □ Please describe: ____________________________________

____

If you experience any of the following symptoms, please check if the symptom was present before the injury, only after the injury, or both.

Before		After
	Frequent squinting or blinking	
	Unusual head tilt or turn	
	Difficulty understanding what is seen	
	Difficulty recognizing words	
	Difficulty recognizing faces	
	Memory problems	
	Difficulty remembering names of objects	
	Difficulty remembering people's names	
	Confusion / Disorientation	
	Difficulty with time management	
	Difficulty finding objects when grouped together	
	Patterned wallpaper or carpets are bothersome	
	Tunnel vision	
	Portions of a page appear to be missing	
	People or things suddenly appear unexpectedly from one side	
	Looking to the side of objects to see them better	
	Difficulty maintaining eye contact	

	Difficulty using both sides of the body together	
	Awkward or poor balance	
	Confuses right and left	
	Reverses letters or words	
	Bothered by noises	
	Bothered by touch	
	Ears ringing / Tinnitus	

EMPLOYMENT OR SCHOOL

Current position: ____

Briefly describe your daily activities at work or in school: _______________________________________

____

Are you attending full time? Yes □ No □

If no, please explain: ____

Who is managing your return to work? ____

Are you expected to return to work full time? Yes □ No □ When? ___________________________

Are you receiving accommodations? Yes □ No □

If yes, please explain: ____

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 □

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? _____ How far away is the monitor? ______

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: ____

Are you driving? Yes □ No □ Describe your experience in a vehicle: _________________________________

____

Are you involved with athletics? Yes □ No □ Do you feel you are achieving up to your? Yes □ No □

Describe additional types of activities that comprise most of your leisure time: _________________________

____

RELEASE OF INFORMATION 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 visual status.