MILTON EYE CARE

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ADULT VISION QUESTIONNAIRE

Please fill out this questionnaire and return it to our office at the time or before your appointment. Thank you.

Patient's full name: ______________________ Date of Birth: ______________________

Address: ______________________ Phone number: ______________________

______________________ Email: ______________________

Occupation: ______________________ ☐Male ☐Female

Were you referred to our clinic? ☐Yes ☐No

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

MEDICAL HISTORY

Family Doctor: ______________________ Allergies: ______________________

Date of Last Medical Exam: ______________________

Medical conditions: ______________________

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Medications (incl. vitamins/supplements): ______________________

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VISUAL HISTORY

Main reason for having an examination today? ______________________

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Date of last eye exam: ______________________ Optometrist: ______________________

Please describe any previous eye or vision problems and treatment you have received (including glasses, vision therapy, patching, surgery, medications, etc.): ______________________

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Do you wear glasses or contact lenses? ☐Glasses ☐Contact lenses ☐None

If yes, when? ______________________ When did you begin wearing glasses? ______________________

Do you experience any of the following: (Please check all that apply)

- ☐ Headaches
- ☐ Double Vision
- ☐ Crossed or wandering eye
- ☐ Blurred Vision (near)
- ☐ Eyes hurt or tired
- ☐ Difficulty tracking an object
- ☐ Blurred Vision (far/dist)
- ☐ Squinting
- ☐ Closes or covers one eye
- ☐ Tilts head
- ☐ Motion/car sickness
- ☐ Burning, itching or tearing
- ☐ Light sensitive
- ☐ Eye injury or surgery
- ☐ Nausea with visual tasks
- ☐ Difficulties with memory
- ☐ Confuses left & right
- ☐ Focus goes in and out
- ☐ Avoids reading
- ☐ Poor handwriting
- ☐ Poor reading comprehension
- ☐ Poor, inefficient reading
- ☐ Loses place while reading
- ☐ Skips, rereads or omits words/lines
- ☐ Poor spelling
- ☐ Holds book really close
- ☐ Difficulty looking from one distance to another
- ☐ Math difficulty (facts/ concepts)
- ☐ Frequent letter, number or word reversals
- ☐ Loses attention easily
- ☐ Vocalizes when reading
- ☐ Words moving/running together
- ☐ Uses finger to track along line when reading

Any other concerns about your vision? ____

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