

**General Information**

Date: \_\_\_\_\_

Full Name: \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Marital status: Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_

Were you referred to our office? Yes \_\_\_ No \_\_\_

If yes, whom may we thank for this referral? \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

What is your occupation? \_\_\_\_\_ Employer: \_\_\_\_\_

Business Address: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_

**Present Situation**

Why do you feel the need for an evaluation? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How long has this problem/difficulty existed? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Employment or School**

Current position: \_\_\_\_\_ Major course of study: \_\_\_\_\_

How many hours daily do you spend at a desk? \_\_\_\_\_

How many hours daily do you spend reading or studying? \_\_\_\_\_

How many hours daily do you spend working at near distances? \_\_\_\_\_

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 work?  
\_\_\_ Yes \_\_\_ No \_\_\_

Describe briefly your daily activities at work or in school:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Hobbies/Sports**

Describe the types of activities that comprise the majority of your leisure time:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you watch TV? Yes \_\_\_ No \_\_\_

If yes, how many hours per day ? \_\_\_\_\_

How many days per week ? \_\_\_\_\_

Are you seriously involved with athletics? Yes \_\_\_ No \_\_\_

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

List the sports in which you excel: \_\_\_\_\_

List the sports in which you do poorly/avoid: \_\_\_\_\_

**Medical History**

Is there a history of the following? (please check if there is a history)

	<b>Patient</b>	<b>Comments</b>
Diabetes	___	_____
Multiple Sclerosis	___	_____
Blindness	___	_____
Glaucoma	___	_____
High Blood Pressure	___	_____
Strabismus / crossed eye	___	_____
Amblyopia / lazy eye	___	_____
Thyroid Condition	___	_____
Cataracts	___	_____
Brain Tumor	___	_____

Physician's Name: \_\_\_\_\_ Date of most recent evaluation: \_\_\_\_\_

Current State of Health (explain): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Current Medications (please include vitamins and supplements)

\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any foods or medications? No \_\_\_ Yes \_\_\_

If yes, please list: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Current diet: Excellent \_\_\_ Good \_\_\_ Fair \_\_\_ Poor \_\_\_



**Computers**

Do you use a computer in your work, school, or leisure time activities? Yes \_\_\_ No \_\_\_

If so, indicate the types of computer work you perform:

- Word processing
- Programming
- Data entry
- Internet
- Games / Leisure activities
- Other (explain): \_\_\_\_\_

How many hours do you spend in front of a computer screen each day? \_\_\_\_\_

How do your eyes feel after working at the computer? \_\_\_\_\_

Where is the top of the screen located?     \_\_\_ Above your straight-ahead eye level  
  \_\_\_ At eye level  
  \_\_\_ Below eye level

What is the distance from your eyes to . . . . the screen ? \_\_\_\_\_  
  . . . . the keyboard ? \_\_\_\_\_  
  . . . . your source documents ? \_\_\_\_\_

Where is the computer located?  
\_\_\_ Directly in front of you when seated  
\_\_\_ To your right  
\_\_\_ To your left

Where are your source documents located?  
\_\_\_ Directly in front of you when seated  
\_\_\_ To your right  
\_\_\_ To your left  
\_\_\_ Flat (horizontal) or vertical

Do you experience any of the following problems in your work area?  
\_\_\_ Glare from windows or other light sources  
\_\_\_ Reflections on your computer screen  
\_\_\_ Difficulty reading source documents

Do you wear glasses, contact lenses, or other optical devices for computer work?  
\_\_\_ Glasses  
\_\_\_ Contact lenses  
\_\_\_ Other (explain): \_\_\_\_\_

Please describe any problems you have with your vision, current glasses or contact lenses for computer work:

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**Symptom Checklist** – Do you experience any of the following?

	<b><u>No</u></b>	<b><u>Yes</u></b>	<b><u>If yes, when?</u></b>
Blurred vision at distance	_____	_____	_____
Blurred vision at near	_____	_____	_____
Red or itchy eyes	_____	_____	_____
Frequent styes	_____	_____	_____
Watery eyes	_____	_____	_____
Eyes hurt	_____	_____	_____
Eyes feel tired	_____	_____	_____
Headaches	_____	_____	_____
Nausea associated with visual tasks	_____	_____	_____
Halos around lights	_____	_____	_____
Double vision at distance	_____	_____	_____
Double vision at near	_____	_____	_____
Tilt head during desk work	_____	_____	_____
Squinting, covering or closing one eye	_____	_____	_____
Postural changes when doing desk work	_____	_____	_____
Need for very bright light when reading	_____	_____	_____
Need for very dim light when reading	_____	_____	_____
Loss of interest for close work	_____	_____	_____
Short attention span for close work	_____	_____	_____
Difficulty sustaining reading/writing	_____	_____	_____
General fatigue at the end of the day	_____	_____	_____
Visual fatigue at the end of the day	_____	_____	_____
Loss of place often when reading	_____	_____	_____
Skip lines when reading	_____	_____	_____
Repetition of letter or words when reading	_____	_____	_____
Omission of words when reading / copying	_____	_____	_____
Use of finger to keep place	_____	_____	_____
Head moves when reading	_____	_____	_____
Confusion of what is being seen or read	_____	_____	_____
Falling asleep when reading	_____	_____	_____
Silent vocalization while reading	_____	_____	_____
Moving lips while reading	_____	_____	_____
Motion sickness (car sickness)	_____	_____	_____
Difficulty with reading comprehension	_____	_____	_____
Comprehension decreases over time	_____	_____	_____
Letters or words appear to move or float	_____	_____	_____
Difficulty aligning columns of numbers	_____	_____	_____
Can respond better orally than in writing	_____	_____	_____
Write or print poorly	_____	_____	_____
Poor time management	_____	_____	_____

**Symptom Checklist (cont.)**

Inconsistent performance in work or sports	___	___	_____
Poor general coordination / clumsiness	___	___	_____
Poor fine motor coordination	___	___	_____
Difficulties with short – term memory	___	___	_____
Difficulties with long – term memory	___	___	_____

Comments on any items above: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Release of Information**

No    Yes    I agree to permit information from, or copies of, my examination records to be forwarded to other professionals (i.e. teachers, health care providers, or insurance carriers) when it is necessary for the treatment of my visual condition or for the processing of insurance claims.

I request that the following individuals be allowed access to information pertaining to my records (i.e. parents, grandparents, significant other).

Note: You may change this list at any time.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

**Financial Statement**

I understand that all fees are due at the time of the exam unless prior arrangements have been made. I agree to pay the normal charges for these medical services. If it becomes necessary, I agree to pay all costs of collection, including attorney fees.

\_\_\_\_\_  
 Signature of Patient or Authorized Representative

\_\_\_\_\_  
 Date

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