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)

	Patient	Comments
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 ☐

Visual History

Have you had an eye examination? No ☐ Yes ☐
If yes, Doctor's name_____ Date of last Visit _____
Address _____
Reason for examination: _____
Results and recommendations: _____
_____

Were glasses, contact lenses, or other optical devices prescribed or recommended?
No ☐ Yes ☐ If so, what was prescribed? _____
Do you use them? Yes ☐ No ☐
How long have you had them? _____
If used, when? _____
If not, why not? _____

If you wear contact lenses, how long have you worn them? _____
What type of lenses do you have (i.e. hard, soft, gas-permeable)? _____
What solutions do you use? _____

Please list family members (i.e. parents, grandparents, brothers, sisters) who have had eye problems:

Name	**Age of Onset**	**Visual Condition**
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

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:

_____
_____
_____
_____

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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