General Information

Date:_____

Full Name: _____ Male____ Female ____
Birth Date: _____ Age: _____ Email: _____
Home Address: _____
_____
Home Phone: _____ Cell Phone: _____
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? _____ Work Phone:_____
Employer: _____
Business Address: _____

Spouse's Name: _____ Phone: _____
Occupation: _____Spouse's Employer: _____
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:_____Phone:_____

Address: _____

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 ___ Date of last Visit:_____
If yes, Doctor's name_____Phone: _____
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:

_____
_____
_____
_____

Symptom Checklist

Do you experience any of the following?	No	Yes	If yes, when?
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

_____
Printed Name of Signee

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