



**Advanced Family Eyecare**

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**VISION REHABILITATION QUESTIONNAIRE**

*Please fill out this questionnaire carefully and return it to our office via website, mail, email or fax prior to your appointment.*

Appointment: Day \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Patient's Name: \_\_\_\_\_

**GENERAL INFORMATION**

Patient Name: \_\_\_\_\_  Male  Female

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

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

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

Email Address: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Legally Separated  Widowed

Race:  White  American Indian or Alaska Native  Asian  Black or African American  Hispanic  Native Hawaiian/  
other Pacific Island

Ethnicity:  Not Hispanic or Latino  Hispanic or Latino  Native Hawaiian/other Pacific Island

Preferred Language:  English  Spanish

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

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

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

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

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

If referred, who referred you? \_\_\_\_\_

May we use your name in thanking them?  Y  N

**MEDICAL HISTORY**

Date of injury/accident: \_\_\_\_\_

Type of injury/accident:  Motor Vehicle  Fall  Blow to Head  Industrial Accident  Medication Related  Drug Abuse  
 Poison or toxic substance  Carbon Dioxide  Drowning  Cord around neck  Stroke  Aneurysm  
 Hemorrhage  Other \_\_\_\_\_

What part of your head was affected? (check all that apply)

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

Was the injury OPEN HEAD (bleeding) or CLOSED HEAD (non-bleeding)? \_\_\_\_\_

Did you lose consciousness?  Yes  No If yes, for how long? \_\_\_\_\_

Were you in a coma?  Yes  No If yes, how long? \_\_\_\_\_

Symptoms immediately following injury: (check all that apply)

Double vision  Headache  Blurred vision  Pain in or around eyes  Dizziness  Vomiting  Flashes of light

Disorientation  Loss of balance  Neck pain/whiplash  Loss of memory  Restricted field of view  Restricted

motion  Other: \_\_\_\_\_

INITIAL TREATMENT

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

Name of doctor: \_\_\_\_\_ Specialty: \_\_\_\_\_

Where were you seen? \_\_\_\_\_ Were you hospitalized?  No  Yes, how long? \_\_\_\_\_

What were you and your family told? \_\_\_\_\_

What did the initial treatments consist of? \_\_\_\_\_

What prognosis/recommendations were you given? \_\_\_\_\_

Were you given medications?  No  Yes, list medication and indicate for what condition(s): \_\_\_\_\_

\_\_\_\_\_

List any medications, including vitamins and supplements used at the current time: \_\_\_\_\_

\_\_\_\_\_

SUBSEQUENT CARE/OTHER PROFESSIONAL CARE

What types of professional care have you received or are you currently receiving? (check all that apply and describe)

Physician - Name: \_\_\_\_\_ Date: \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

Neurologist - Name: \_\_\_\_\_ Date: \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

Neuropsychologist - Name: \_\_\_\_\_ Date: \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

Physical Therapist - Name: \_\_\_\_\_ Date: \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

Speech/Language Therapist - Name: \_\_\_\_\_ Date: \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

Psychologist/Psychiatrist - Name: \_\_\_\_\_ Date: \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

Osteopathic Physician - Name: \_\_\_\_\_ Date: \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

Other - Name: \_\_\_\_\_ Date: \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

Do you have a history of allergies?  Yes  No

If yes, please explain: \_\_\_\_\_

Has a neurological evaluation been performed?  Yes  No

If yes, by whom? \_\_\_\_\_ Date: \_\_\_\_\_

Results: \_\_\_\_\_

Has a psychological evaluation been performed?  Yes  No

If yes, by whom? \_\_\_\_\_ Date: \_\_\_\_\_

Results: \_\_\_\_\_

Has a speech and language evaluation been performed?  Yes  No

If yes, by whom? \_\_\_\_\_ Date: \_\_\_\_\_

Results: \_\_\_\_\_

MEDICAL HISTORY

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

High Blood Pressure - [ ] Patient [ ] Family: \_\_\_\_\_ Glaucoma [ ] Patient [ ] Family: \_\_\_\_\_
Diabetes [ ] Patient [ ] Family: \_\_\_\_\_ Cataracts [ ] Patient [ ] Family: \_\_\_\_\_
Thyroid Condition [ ] Patient [ ] Family: \_\_\_\_\_ Blindness [ ] Patient [ ] Family: \_\_\_\_\_
Multiple Sclerosis [ ] Patient [ ] Family: \_\_\_\_\_ Strabismus [ ] Patient [ ] Family: \_\_\_\_\_
Brain Tumor [ ] Patient [ ] Family: \_\_\_\_\_ Amblyopia [ ] Patient [ ] Family: \_\_\_\_\_
Traumatic Brian Injury [ ] Patient [ ] Family: \_\_\_\_\_ Stroke [ ] Patient [ ] Family: \_\_\_\_\_

VISUAL HISTORY

Have you had a previous vision evaluation? [ ] Yes [ ] No

If yes, doctor's name: \_\_\_\_\_

Date of last evaluation: \_\_\_\_\_

Reason for examination: \_\_\_\_\_

Were glasses, contact lenses, or other optical devices recommended? [ ] Yes [ ] No

If yes, what? \_\_\_\_\_

Are they used? [ ] Yes [ ] No If yes, when? \_\_\_\_\_

If no, why not? \_\_\_\_\_

Where any additional tests treatments or therapies recommended concerning your vision? [ ] Yes [ ] No

If yes, what? \_\_\_\_\_

Did you undergo these treatments? [ ] Yes [ ] No Explain: \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING:

Table with 3 columns: Yes, No, Prior to Injury?
Eyes ache..... [ ] [ ] [ ]
Eyes pull or drag ..... [ ] [ ] [ ]
Difficulty moving or turning eye ..... [ ] [ ] [ ]
Pain with movement of eyes..... [ ] [ ] [ ]
Eyes twitch..... [ ] [ ] [ ]
Pain in or around eyes..... [ ] [ ] [ ]
Eye redness..... [ ] [ ] [ ]
Burning eyes..... [ ] [ ] [ ]
Watery eyes..... [ ] [ ] [ ]
Itchy eyes..... [ ] [ ] [ ]
Brightness is bothersome..... [ ] [ ] [ ]
Motion sickness/car sickness..... [ ] [ ] [ ]
Headaches..... [ ] [ ] [ ]
Blurred vision..... [ ] [ ] [ ]
Double vision ..... [ ] [ ] [ ]
One eye turns in, out, up or down ..... [ ] [ ] [ ]
Movement of objects in the environment is bothersome ..... [ ] [ ] [ ]
Fluorescent light is bothersome ..... [ ] [ ] [ ]
Patterned wallpaper or carpets are bothersome ..... [ ] [ ] [ ]
Head moves when reading ..... [ ] [ ] [ ]
Lose place often when reading ..... [ ] [ ] [ ]
Words jump or move around when reading ..... [ ] [ ] [ ]
Short attention span for reading or writing ..... [ ] [ ] [ ]

- Skip words frequently when reading.....
- Discomfort when reading .....
- Loss of interest/concentration
  - doing close work .....
- Orient writing/drawing poorly on page..
- Squinting, covering or closing one eye....
- Head tilts during desk work.....
- Hold books too close .....
- Avoid reading or writing .....
- Difficulty with peripheral vision.....
- Objects jump in and out of field view.....
- Reduced depth perception .....
- Tunnel vision/ Loss of visual field .....
- Flashes of light .....
- Difficulty with dressing .....
- Difficulty with bathing/personal hygiene
- Difficulty following a series of directions
- Difficulty using both sides of the body
  - together .....
- Dislikes heights .....
- Awkward, poor balance .....
- Dizziness .....
- Confusion/disorientation .....
- Get lost often .....
- Bothered by noises .....
- Bothered by touch .....
- Difficulty remembering things heard .....
- Difficulty remembering things seen .....
- Difficulty remembering names of objects
- Difficulty remembering people's names ..
- Difficulty recalling information known
  - in the past .....
- Difficulty remembering formerly
  - familiar people/objects .....
- Difficulty performing tasks formerly
  - easy/routine .....
- Difficulty with time management .....
- Difficulty with numbers .....
- Difficulty counting numbers .....

Why do you feel you need a vision evaluation today?

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**LIFESTYLE**

Do you feel your vision interferes with activities of daily living?  Yes  No

If yes, please explain (please include effects involving home, work, hobbies, social relationships and personal relationships):

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What activities comprise the majority of your daily life since your accident/injury? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What activities can you no longer engage in due to your visual or other difficulties? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What other changes/limitations in your daily life do you attribute to your accident/injury? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you hope a Visual Rehabilitation Program can do for you? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

EMPLOYMENT/EDUCATION INFORMATION (if applicable)

What is your current employment position? \_\_\_\_\_  
If a student, what is the major course of study? \_\_\_\_\_  
How many hours daily are spent at a desk? \_\_\_\_\_  
How many hours daily are spent working at near distance? \_\_\_\_\_  
How many hours daily are spent reading/studying? \_\_\_\_\_  
How many hours daily are spent with a computer? \_\_\_\_\_

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RELEASE OF INFORMATION

**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 this exchange of information.**

I authorize the release of medical information to other health care providers or insurance carriers upon their written request, or upon the recommendation of the Advanced Family Eyecare when it is necessary for the treatment of my visual condition. This authorization shall be considered valid for the duration of my treatment.

Signature of authorized patient or 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 and to better meet your specific visual needs.

If at any time you have any questions or concerns regarding your vision or treatment, please do not hesitate to contact us. You may leave a message for us 24 hours a day, 7 days a week.

Please request a minimum of 24 hours notice if you are unable to keep this appointment.

Please be on time for your evaluation so that we may have the maximum opportunity to evaluate your visual status.

Thank you.

Sincerely,

Samuel C. Oliphant, O.D., F.A.A.O.