NORTH PARK VISION CENTER

Marcy Rose, O.D., F.C.O.V.D.

Patient's Name:_____

Full Legal Name:		Female ☐ Male ☐
Birth Date:	Age: years:	months:
Occupation:	Place of work:	Email:
Address:	City/State:	Zip:

Illnesses, head/neck injuries, stroke, high fevers, eye injuries, eye surgery etc.:

Condition mild **Severity** severe **Complications**

Age	1	2	3	4	5	6	7	8	9	10	

Have you or any one in your family been treated for the following:

	You	Family	Whom:		You	Family	Whom:
Neurological				Chromosomal Imbalance			
Multiple Sclerosis				Autism Spectrum Disorder			
Epilepsy or Seizures				Learning Disability			
"Cross"/"Wall" eye				ADHD			
Amblyopia (lazy eye)				ADD			
Glaucoma				Macular Degeneration			
Color Deficiency				Retinal Detachment			
Loss of field of vision/restricted field				Smokes Cigarettes			
Blindness				Drinks Alcohol			
				Other			

Has a neurological evaluation been performed?	**Y**	**N**
By whom?	Results and recommendations:	

Please check all of the following that apply to you:					
Headaches/ Migraines		Motion Sick		Light sensitivity	
Blurred Far Vision		Car Sick		Flashing lights	
Blurred Near Vision		Squinting		Floaters	
Double Vision		Dry eyes		Frequent Styes	
Eyes ache		Red eyes		Eyes itching	
Eyes burn		Frequent blinking		Frowning	
Eyes tired		Excessive rubbing		Eye Surgery:	
Eyes tearing/watering		Covers an eye		Crossed Eye	
Eye Pain		Closes an eye		Wall eyed	
Dizziness		Poor reading comprehension		Poor attention/concentration	
Difficulty tracking		Poor/inefficient reading		Memory problems	

Thank you for carefully completing this questionnaire,

Dr. Rose and Associates