2822 Venture Drive | Marquette, MI 49855 | phone: 906.228.4401 | fax: 906.225.0460 | superioreye@hotmail.com

General Information

Patient's full name________________________
Home phone number________________________
Fax number________________________
E-mail________________________
Home address________________________
City____________ State________ Zip________
Social Security Number________________________
Age________ Birthdate________________
Sex: M F Marital Status: S M D W
Employer________________________
Address________________________
City____________ State________ Zip________
Work phone number________________________
If married, name of spouse________________________
Primary Health Care Plan________________________
____
Policy number________________________
Insured person________________________
Insured Social Security Number________________________
Emergency contact________________________

Medical History

Date of injury________________________
Explanation of Injury________________________
____
____
____
____
Date of most recent medical exam________________________
Name of physician________________________
Date of last vision examination________________________
Name of doctor________________________
Results________________________
____

Head Trauma History

Please return this form so our staff may schedule appropriatley; or at least ONE WEEK prior to your appointment in the enclosed envelope. This assists Dr. Johnson in determining the visual performance tests needed.

Medications currently using________________________
____
____
For what condition(s)________________________
____
____

Please fill in any of the following professionals that you have seen related to your injury:

- ☐ Psychiatrist ☐ Psychologist ☐ Family Physician
- ☐ Neurologist ☐ Osteopath ☐ Speech Therapist
- ☐ Psychologist ☐ Chiropractor ☐ Physical Therapist
- ☐ Massage Therapist ☐ Neuropsychologist
- ☐ Opthalmologist ☐ Emergency Room Doctor
- ☐ Audiologist/Otolaryngologist ☐ Occupational Therapist
- ☐ Other________________________

Names of above physicians:

1) ________________________
2) ________________________
3) ________________________
4) ________________________
5) ________________________

Any history of the following? (please fill in)

	You	Family
High blood pressure:	☐	☐
Strabismus:	☐	☐
Diabetes:	☐	☐
Thyroid Condition:	☐	☐
Blindness:	☐	☐
Multiple Sclerosis:	☐	☐
Brain Injury:	☐	☐
Stroke:	☐	☐
Amblyopia:	☐	☐
Brain Tumor:	☐	☐
Cataracts:	☐	☐
Glaucoma:	☐	☐

Do you experience the following? (please fill in)

	Yes	No
Brightness bothers you	☐	☐
Difficulty in stores or malls	☐	☐
Motion sickness	☐	☐
Head turns as reading across page	☐	☐
Eye ache	☐	☐
Losing place often when reading	☐	☐
Headaches	☐	☐
Using finger to keep place	☐	☐
Blurred vision	☐	☐
Short attention span for close work	☐	☐
Eye redness	☐	☐
Skipping words frequently when reading	☐	☐
Double Vision	☐	☐
Orient drawing poorly on page	☐	☐
One eye turns in or out	☐	☐
Squinting covering or closing one eye	☐	☐
Burning eyes	☐	☐
Tilting head during desk work	☐	☐
Eye drainage	☐	☐
Fatigues easily	☐	☐
Itching eyes	☐	☐
Holding books too closely	☐	☐
Delayed dressing skills	☐	☐
Avoid near tasks	☐	☐
Dislike heights	☐	☐
Difficulty following series of directions	☐	☐
Awkward, poor balance	☐	☐
Difficulty using both sides of body together	☐	☐
Patterned wallpapers/carpet bothersome	☐	☐
Movement of objects in the environment are bothersome	☐	☐

Motor Vehicle Accident

Type of vehicle you were in ____________________

Other vehicle(s) involved ____________________

Were you sitting in:

☐ Front Seat ☐ Back Seat ☐ Middle

☐ Left Side ☐ Right Side ☐ Unusual Position

Which restraints were used? (Check all that apply)

☐ Lap ☐ Shoulder ☐ Car Seat

☐ Booster Seat ☐ Air Bag

Speed of vehicle you were in ____________________

Speed of other vehicle or object ____________________

Did your vehicle hit another object?

☐ Yes ☐ No

Or did the other vehicle hit your vehicle?

☐ Yes ☐ No

If yes, where was your vehicle hit?

☐ Head on ☐ Toward Front ☐ Driver side

☐ Rear ended ☐ Toward rear ☐ Passenger side

Did you experience whiplash?

☐ Yes ☐ No

Did you hit your head?

☐ Yes ☐ No

If yes, on what ____________________

____

____

____

I authorize the release of any medical information to process my insurance claim or the referral to another doctor, school or clinic; I also allow payment from insurance to be sent directly to Superior Eye Health and Vision Therapy Center.

Signed ____________________

Date ____________________