BOAS
VISION ASSOCIATES

Mark B. Boas, OD, MS | Suzanne O. Boas, OD | Marie K. Gwinn, OD | Katherine R. Boas, OD | Megan Lynott, OD, FAAO

Traumatic Brain Injury Patient Questionnaire

Patient's Name___________________________
Date of Birth_____________________________
Today's Date_____________________________

Who referred you to our office for evaluation of your vision?
Name: ___________________________
Specialty: ________________________
Address: ____

What **date** did your accident, injury, or stroke occur? ____________________________

How did your brain injury occur?
____
____
____
____
____

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

___Forehead ___Back of head ___Face
___Right side ___Top of head ___Whiplash/Neck
___Left side

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

Did you lose consciousness? YES or NO If yes, for how long? _______________

Were you in a coma? YES or NO If yes, for how long? ________________

Are you involved in a lawsuit/workman's compensation case as a result of your injury? YES or NO

What were your symptoms **immediately following** the accident or injury? (check all that apply):

___Double vision ___Loss of balance ___Pain in or around eyes ___Restricted field of view
___Blurred vision ___Loss of memory ___Vomiting ___Neck pain/whiplash
___Dizziness ___Restricted motion ___Disorientation ___Headache
___Flashes of light Other: _____________________________________

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VISUAL HISTORY

Have you had a previous vision evaluation for this injury? Yes □ No □
If yes, doctor's name: ___________________________
Date of last evaluation: __________________________

Reason for today's examination:

Do you wear glasses? Yes No

Do you wear contact lenses? Yes No

Do you wear bifocals? Yes No

Do you wear progressive lenses? Yes No

Do your glasses work as well now as before the injury? Yes No

Were new glasses, contact lenses, or other optical devices recommended after the injury? Yes No

If yes, what? ____

Are they used? Yes □ No □ If yes, when? ____
If not, why not? ____

Were any additional tests, treatments, or therapies recommended concerning your vision?
Yes □ No □
If yes, what? ____

Did you undergo these treatments? Yes □ No □ Explain: ____

What were the results of the treatments?

Were other recommendations made and what were they?

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING?

	Yes	No	Prior to Injury?
Blurred vision	☐	☐	☐
Eyes ache	☐	☐	☐
Pain in or around eyes	☐	☐	☐
Pain with movement of eyes	☐	☐	☐
Headaches	☐	☐	☐
Eye redness	☐	☐	☐
Burning eyes	☐	☐	☐
Watery eyes	☐	☐	☐
Itchy eyes	☐	☐	☐
Brightness is bothersome	☐	☐	☐
Fluorescent light is bothersome	☐	☐	☐
Difficulty moving or turning eyes	☐	☐	☐
Difficulty changing focus far to near	☐	☐	☐
Eyes pull or tug	☐	☐	☐
Eyes twitch	☐	☐	☐
Motion sickness/car sickness	☐	☐	☐
Movement of objects in the environment is bothersome	☐	☐	☐
Double vision	☐	☐	☐
One eye turns in, out, up or down	☐	☐	☐
See overlapping images or shadowed images?	☐	☐	☐
Squinting, covering, or closing one eye	☐	☐	☐
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 concentration when doing close work	☐	☐	☐
Have difficulty following moving targets	☐	☐	☐
Use your finger or an underliner when reading	☐	☐	☐
Orients writing/drawing poorly on page	☐	☐	☐
Head tilts during desk work	☐	☐	☐
Hold books too close	☐	☐	☐
Avoid reading or writing	☐	☐	☐
Difficulty with peripheral vision	☐	☐	☐
Objects jump in and out of field of view	☐	☐	☐
Reduced depth perception	☐	☐	☐
Tunnel vision/loss of visual field	☐	☐	☐
Flashes of light	☐	☐	☐
Bump into things, objects, chairs, or walls	☐	☐	☐
Trip or fall	☐	☐	☐
Trouble seeing at night	☐	☐	☐

	Yes	No	Prior to Injury?
Hold onto things, walls, or people when you walk	☐	☐	☐
Often knock things over	☐	☐	☐
Clumsiness	☐	☐	☐
Portions of objects or pages ever missing	☐	☐	☐
Startled by people or objects	☐	☐	☐
Difficulty with dressing	☐	☐	☐
Difficulty with bathing/personal hygiene	☐	☐	☐
Difficulty following a series of directions	☐	☐	☐
Difficulty using both sides of the body together	☐	☐	☐
Awkward, poor balance	☐	☐	☐
Dizziness	☐	☐	☐
Confusion/disorientation	☐	☐	☐
Get lost often	☐	☐	☐
Bothered by noises	☐	☐	☐
Difficulty remembering things heard	☐	☐	☐
Difficulty remembering things seen	☐	☐	☐
Difficulty remembering name of objects	☐	☐	☐
Difficulty remembering people’s names	☐	☐	☐
Difficulty recalling information known in the past	☐	☐	☐
Difficulty remembering formerly familiar people/objects	☐	☐	☐
Difficulty performing tasks that were formerly easy/routine	☐	☐	☐
Difficulty with time management	☐	☐	☐
Difficulty with numbers	☐	☐	☐

Patient’s printed name: ____

Signature of patient/guardian: __________________________________

Today’s date: ____

Please complete the following with as much detail as possible. We use this information to correspond with all persons/doctors involved in your care. If it is easier, you may give us business cards and we will attach them to this form.

Primary Care Physician:

Name: ______________________________
Address: ______________________________
____
____
Phone: ______________________________
Email: ______________________________

Optometrist or Ophthalmologist:

Name: ______________________________
Address: ______________________________
____
____
Phone: ______________________________
Email: ______________________________

Physiatrist:

Name: ______________________________
Address: ______________________________
____
____
Phone: ______________________________
Email: ______________________________

Neuropsychologist:

Name: ______________________________
Address: ______________________________
____
____
Phone: ______________________________
Email: ______________________________

Physical Therapist:

Name: ______________________________
Address: ______________________________
____
____
Phone: ______________________________
Email: ______________________________

Occupational Therapist:

Name: ______________________________
Address: ______________________________
____
____
Phone: ______________________________
Email: ______________________________

Speech/Cognitive Therapist:

Name: ______________________________
Address: ______________________________
____
____
Phone: ______________________________
Email: ______________________________

Ears/Nose/Throat Physician or Audiologist:

Name: ______________________________
Address: ______________________________
____
____
Phone: ______________________________
Email: ______________________________

Other Physician(s):

Name: ______________________________
Address: ______________________________
____
____
Phone: ______________________________
Email: ______________________________