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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: _____



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?

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

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

Patient's printed name: _____

Signature of patient/guardian: _____

Name(s) of those accompanying patient: _____

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: _____

Lawyer/Attorney:

Name: _____
Address: _____

Phone: _____
Email: _____

Other Physician(s):

Name: _____
Address: _____

Phone: _____
Email: _____