Adult Patient Information

Name:_____

Who referred you to Eye Health Centre? _____

Patient History Questionnaire

Please fill out questionnaire carefully and return it to the office at the time of your appointment. The time spent answering questions will allow the doctor to better plan the flow of the examination procedures.

Thank you for your time and effort in completing this questionnaire. Leave blank or put N/A besides questions that do not apply.

PRESENT SITUATION AND SYMPTOMS

What are the concerns that prompted this functional vision evaluation?

_____
_____
_____
_____

How long have these concerns been observed? _____

What goals do you hope to accomplish from the functional vision evaluation?
_____

VISUAL HISTORY

Last Eye Exam (year) _____   Doctor: _____   City:_____

Were glasses, contact lenses or other optical devices prescribed or recommended? If so, what? and do you use them? If not using them, why?

_____
_____

Explain any history of eye surgeries, eye/head injury, vision therapy or other treatments in the past (related or not to current concerns)

-
_____
_____

Quality of Life Checklist

COLLEGE OF OPTOMETRISTS IN VISION DEVELOPMENT
PREVENTION • ENHANCEMENT • REHABILITATION

Patient Name: _____

Form Completed by: _____

Date: _____

Check the column which best represents the occurrence of each symptom	Never 0	Seldom 1	Occasionally 2	Frequently 3	Always 4
Blurred close vision					
Double vision					
Headaches with near work					
Words run together reading					
Burning, itchy, watery eyes					
Falls asleep reading					
Sees worse at the end of day					
Skips/repeats lines reading					
Dizzy/nauseated by near work					
Head tilt/one eye closed to read					
Difficulty copying from chalkboard					
Avoids near work/reading					
Omits small words when reading					
Writes uphill/downhill					
Misaligns digits/columns of numbers					
Poor reading comprehension					
Poor/inconsistent in sports					
Holds reading too close					
Trouble keeping attention on reading					
Difficulty completing work on time					
Says "I can't" before trying					
Avoids sports/games					
Poor hand/eye coordination					
Poor handwriting					
Does not judge distance accurately					
Clumsy, knocks things over					
Poor time use/management					
Does not make change well					
Loses things/belongings					
Car or motion sickness					
Forgetfulness/poor memory					
Total for each column:	x 0 = 0	__x1 =__	__x2 =__	__x3 =__	__x4 =__
Grand Total:					

<15 = Routine eye exam recommended   **16-24** = Comprehensive exam with developmental OD recommended   **>25** = Developmental vision problem likely, comprehensive exam with developmental OD strongly recommended

Any other symptom/concerns not mentioned in the previous checklist? _____

COMPUTER

Do you use computers in your work, school or leisure time activities? _____

If so, indicate the types of computer work you perform:

___ Word processing   ___ Programming   ___ Data Entry   ___ Internet

___ Games   ___ Others: _____

How many hours do you spend in front of a computer screen in a day? _____

How do your eyes feel after working at the computer? _____

Do you use multiple screens? _____

Is your computer screen about arms length away from you? _____ If not, what distance is it? _____

HOBBIES/SPORTS

Describe the activities that comprise the majority of your leisure time:

_____

Do you watch TV? ___ yes _____ no   If yes, how many hours per week? _____

Are you involved in athletics? _____ yes _____ no

List the sports in which you participate: _____

Are there any activities/sports you would like to participate in but don't? If so, please explain
_____
_____

EMPLOYMENT OR SCHOOL

Current Position: _____ or Major course of study: _____

How many hours per day do you spend sitting at a desk? _____

How many hours per day do you spend reading of studying? _____

How many hours per day do you spend working at near distances? _____

Do you feel you are achieving your potential at work or school? _____ yes _____ no

Do you feel you are getting adequate return from the amount of effort you put into a task? __yes __ no

Describe briefly your daily activities at work or at school: _____

Have you ever had a concussion _____yes _____ no. If yes, give details _____