EYE Health Centre

#114, 506 St. Albert Trail
St. Albert, AB
T8N 5Z1
780-419-7000

Adult Patient Information

Name:_____ Birth Date:_____

Address:_____

_____

Phone(day): _____

Would you prefer email correspondence? If so, email address_____

Who referred you to Eye Health Centre? _____

Patient History Questionnaire

Please fill out questionnaire carefully and return it to the office 1 week prior to 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?

_____
_____
_____
_____

What caused the onset of these symptoms (MVA, fall, sport related)?_____

Give us as much detail as you can about that incident (date, location, loss of consciousness…)?

_____

_____

_____

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 (not related to current concerns)

_____
_____
_____

COMPUTER

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

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 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: _____

Brain Injury Vision Symptom Survey
BIVSS

Name:_____
MR:_____Date:_____

0 = Never 1 = Seldom 2 = Occasionally 3 = Frequently 4 = Always

EYESIGHT CLARITY					
Distance vision blurred and not clear - even with lenses	0	1	2	3	4
Near vision blurred and not clear - even with lenses	0	1	2	3	4

Please rate each behaviour

How often does each behaviour occur? (circle a number)

Clarity of vision changes or fluctuates during the day	0	1	2	3	4
Poor night vision / can't see well to drive at night	0	1	2	3	4

VISUAL COMFORT					
Eye discomfort / sore eyes / eystrain	0	1	2	3	4
Headaches or dizziness after using eyes	0	1	2	3	4
Eye fatigue / very tired after using eyes all day	0	1	2	3	4
Feel "pulling" around the eyes	0	1	2	3	4

DOUBLING					
Double vision - especially when tired	0	1	2	3	4
Have to close or cover one eye to see clearly	0	1	2	3	4
Print moves in and out of focus when reading	0	1	2	3	4

LIGHT SENSITIVITY					
Normal indoor lighting is uncomfortable - too much glare	0	1	2	3	4
Outdoor light too bright - have to use sunglasses	0	1	2	3	4
Indoor fluorescent lighting is bothersome or annoying	0	1	2	3	4

DRY EYES					
Eyes feel "dry" and sting	0	1	2	3	4
"Stare" into space without blinking	0	1	2	3	4
Have to rub eyes a lot	0	1	2	3	4

DEPTH PERCEPTION					
Clumsiness / misjudge where objects really are	0	1	2	3	4
Lack of confidence walking / missing steps / stumbling	0	1	2	3	4
Poor handwriting (spacing, size, legibility)	0	1	2	3	4

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PERIPHERAL VISION					
Side vision distorted / objects move or change position	0	1	2	3	4
What looks straight ahead - isn't always straight ahead	0	1	2	3	4
Avoid crowds / can't tolerate "visually-busy" places	0	1	2	3	4

READING					
Short attention span / easily distracted when reading	0	1	2	3	4
Difficulty / slowness with reading and writing	0	1	2	3	4
Poor reading comprehension / can't remember what was read	0	1	2	3	4
Confusion of words / skip words during reading	0	1	2	3	4
Lose place / have to use finger not to lost place when reading	0	1	2	3	4