Patient Intake Form

Patient Name _____ Date of Birth _____

Reason for today's visit: ☐ Routine Exam ☐ Eye Injury

☐ Surgical Consultation ☐ Surgical Post-Op ☐ Other _____

Please list your current medications:

_____

_____

Please list any allergies:

_____

Ocular / Medical History (Please check if you or an immediate family member has a history of any of the following):

☐ Blindness	☐ Glaucoma	☐ Cancer
☐ Cataracts	☐ Headaches/Migraines	☐ Heart Problems
☐ Diabetes	☐ Macular Degeneration	☐ High Blood Pressure
☐ Dry Eye	☐ Thyroid Problems	☐ High Cholesterol
☐ Eye Trauma	☐ Arthritis	☐ HIV/Aids
☐ Eye Surgery	☐ Asthma	☐ Smoker

☐ Other _____

Do you wear Prescription Glasses: ☐ Yes ☐ No

If yes: ☐ Single Vision ☐ Progressives ☐ Computer

☐ Bifocals ☐ Trifocals

How many hours per day do you spend in front of your computer/electronic devices? _____

Do you currently wear contact lenses? ☐ Yes ☐ No

If yes: How many hours per day do you wear your contact lenses? _____

If no: Have you worn contact lenses in the past? ☐ Yes ☐ No

Are you sensitive to light? ☐ Yes ☐ No

Do you wear sunglasses? ☐ Yes ☐ No

What is your occupation? _____

Please answer the following questions about how your eyes feel when reading or doing close work.

Possible Subjective Symptoms	**Frequency**				
	Never (0)	Infrequently / Not Very Often (1)	Sometimes (2)	Fairly Often (3)	Always (4)
1. Do your eyes feel tired when reading or doing close work?					
2. Do your eyes feel uncomfortable when reading or doing close work?					
3. Do you have headaches when reading or doing close work?					
4. Do you feel sleepy when reading or doing close work?					
5. Do you lose concentration when reading or doing close work?					
6. Do you have trouble remembering what you have read?					
7. Do you have double vision when reading or doing close work?					
8. Do you see the words move, jump, swim, or appear to float on the page when reading or doing close work?					
9. Do you feel like you read slowly?					
10. Do your eyes ever hurt when reading or doing close work?					
11. Do your eyes ever feel sore when reading or doing close work?					
12. Do you feel a "pulling" feeling around your eyes when reading or doing close work?					
13. Do you notice the words blurring or coming in and out of focus when reading or doing close work?					
14. Do you lose your place while reading or doing close work?					
Total Score _____	____ x 0	____ x 1	____ x 2	____ x 3	____ x 4

For Children (< 21) total score = **16 or higher** is suggestive of convergence insufficiency.
For Adults total score = **21 or higher** is suggestive of convergence insufficiency.