5012 Dorsey Hall Drive, Suite 105
Ellicott City, MD 21042

ELLICOTT CITY
TOTAL EYE CARE

ellicottcityeyes.com
410-730-8878

ADULT DEVELOPMENTAL HISTORY

Patient Name: ____________ DOB: ____________ Age: ______

Address: ____________ City: ____________ State: ______ Zip: ______

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Occupation: ____________ Referred by: ____________

Email Address: ____________

What do you expect to find out from the evaluation? ____________

LIFESTYLE

How did you perform in school? ☐ Above Average ☐ Average ☐ Below Average

Do you play sports? ☐ Yes ☐ No If yes, what type and how often? ____________

Other forms of exercise and frequency: ____________

Current hobbies: ____________

On average, how many hours per day do you spend:
On computers ______ Reading ______ Watching TV______ Playing video games ______

Are there any activities that you would enjoy doing, but must restrict because of your vision? ☐ Yes ☐ No
If yes, please explain: ____________

PRESENT SITUATION

How are you experiencing visual difficulty? ____________

How long have you experienced this visual difficulty? ____________

Have you been diagnosed with a concussion? ☐ Yes ☐ No If yes, date of injury? ____________

If yes, have you had any type of therapy for your concussion? ____________

Have you had vision therapy at any time? ____________

Have you had eye surgery? ☐ Yes ☐ No If yes, type and date of occurrence? ____________

PREVIOUS VISUAL EXAMS

Reason for exam	Doctor’s Name	Date	Results

DO YOU EXPERIENCE ANY OF THE FOLLOWING?

Blurred vision at far	☐ Yes ☐ No	Light Sensitivity	☐ Yes ☐ No
Blurred vision at near	☐ Yes ☐ No	Difficulty Driving	☐ Yes ☐ No
Fatigue while reading	☐ Yes ☐ No	Decreased computer tolerance	☐ Yes ☐ No
Lose place while reading	☐ Yes ☐ No	Poor balance	☐ Yes ☐ No
Eye(s) turn in or out	☐ Yes ☐ No	Dizzy spells	☐ Yes ☐ No

5012 Dorsey Hall Drive, Suite 105
Ellicott City, MD 21042

ELLICOTT CITY
TOTAL EYE CARE

ellicottcityeyes.com
410-730-8878

QUALITY OF LIFE CHECKLIST

Patient Name: ______________________ 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 when reading					
Burning, itchy, watery eyes					
Fall asleep reading					
See worse at end of the day					
Skip/repeat lines while reading					
Dizzy/nauseated by near work					
Head tilt/one eye closed to read					
Difficulty copying from board					
Avoid near work/reading					
Omit small words when reading					
Write uphill/downhill					
Misalign digits/columns of numbers					
Poor reading comprehension					
Poor/inconsistent in sports					
Holds reading too close					
Trouble staying focused on reading					
Difficulty completing work on time					
Says, “I can’t” before trying					
Avoids sports/games					
Poor hand/eye coordination					
Poor handwriting					
Difficulty judging distance					
Clumsy, knock over thing					
Poor time use/management					
Does not make change well					
Lose things/belongings					
Car or motion sickness					
Forgetful/poor memory					
Total for each column	____x0=0	____x1=____	____x2=____	____x3=____	____x4=____
Grand Total *(sum of each column)*					