VISUALEYS OPTOMETRY SUSAN H. KIM-LAUBACH, O.D., F.C.O.V.D.
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ADULT VISION QUESTIONNAIRE - EXTENDED

Please fill out this questionnaire <u>carefully</u>. Please return it to our office <u>prior</u> to your appointment. Thank you.

Appointment: Day ________________________ Date ___________________________ Time _____________________
Patient's Name: ____

GENERAL INFORMATION

Full Name: ____ Male Female
Birth Date: _________________ Age: ________
e-mail: ____
Cell Phone: ____ Work Phone: ____
Were you referred to our office? Yes No
If yes, whom may we thank for this referral? ___________________________ Phone: ____________________
Address ____
Do you have Major Medical Insurance? Yes No
If yes, who is the carrier? ____________________________________ Policy #: _________________________________
Does the insurance cover eye examinations or glasses? Yes No
Name of Insured: ____
Social Security Number: ____
What is your occupation? ____ Employer: ______________________________
Business Address: ____
Spouse's Name: ____ Occupation: ______________________________
Spouse's Employer: ____ Phone #: ________________________________
Business Address: ____
Please list your spouse and dependents:

<u>NAME</u>

Spouse ____Birth Date ________________________________
Dependent ____Birth Date ________________________________
Dependent ____Birth Date ________________________________
Dependent ____Birth Date ________________________________
Dependent ____Birth Date ________________________________

MEDICAL HISTORY

Date of most recent evaluation _________________________ Physician's Name: __________________________________
For what problem / condition? ____
Results and recommendations: ____
Medications currently using including vitamins and supplements: ____
For what condition(s)? ____
Are you allergic to any foods or medications? Yes No
If yes, please list: ____
Current diet: Excellent Good Fair Poor
Current state of health (explain): ____

Is there any history of the following? (please check if there is a history)

	Patient	Family	Who
Diabetes			_______
Multiple Sclerosis			_______
Blindness			_______
Glaucoma			_______
High Blood Pressure			_______

	Patient	Family	Who
	Patient	**Family**	**Who**
Strabismus / crossed eye			
Amblyopia / lazy eye			
Thyroid Condition			
Cataracts			
Brainumor			

VISUAL HISTORY

Have you had a previous vision examination? Yes No

If yes, doctor's name: ____________________

Date of last visit: ____________________

Reason for examination: ____________________

Were glasses, contact lenses or other optical devices prescribed or recommended? Yes No

..........If so what? ____________________

Do you use them? Yes No

How long have you had them? ____________________

If used, when? ____________________

If not, why not? ____________________

If you wear contact lenses, how long have you worn them? ____________________

What type of lenses do you have(i.e. hard, soft, gas-permeable)? ____________________

What solutions do you use? ....

Members of the family who have had visual attention and the reason:

Name	Age	Visual Situation

PRESENT SITUATION

Why do you feel the need for a visual evaluation? ____________________

How long has this problem/difficulty existed? ____________________

Do you experience any of the following:

	Yes	No	If yes, when?
Blurred vision at distance			
Blurred vision at near			
Red or itchy eyes			
Burning eyes			
Frequent Sties			
Watery eyes			
Eyes hurt			
Eyes feel tired			
Headaches			
Nausea associate with visual tasks			

	Yes	No	If yes, when?
Halos around lights			
Double vision at distance			
Double vision at near			
Tilt head during desk work			
Squinting, covering or closing one eye			
Postural changes when doing desk work			
Need for very bright light when reading			
Need for very dim light when reading			

Loss of interest or short attention span
for close work ______________
Difficulty sustaining reading / writing ______________
General or visual fatigue at the end of the day ______________
Loss of place often when reading ______________
Skip lines when reading ______________
Repetition of letter or words when reading ______________
Omission of words when reading / copying ______________
Use of finger to keep place ______________
Head moves when reading ______________
Confusion of what is being seen or read ______________
Falling asleep when reading ______________
Silent vocalization/moving lips while reading ______________
Motion / car sickness ______________
Difficulty with reading comprehension ______________
Comprehension decreases over time ______________
Letters or words appear to move or float
around when reading ______________
Difficulty aligning columns of numbers ______________
Can respond better orally than in writing ______________
Write or print poorly ______________
Poor time management ______________
Inconsistent performance in work or sports ______________
Poor general coordination / clumsiness ______________
Poor fine motor coordination ______________
Difficulties with sort-term memory ______________
Difficulties with long-term memory ______________

Comments on any items above: ____

COMPUTERS

Do you use a computer in your work, school, or leisure time activities? Yes No
If so, indicate the types of computer work you perform:

Word processing
Programming
Data entry
Internet
Games / Leisure activities
Other (explain): ______________________________

How many hours do you spend in front of a computer screen each day? ______________
How do your eyes feel after working at the computer? ______________

Where is the top of the screen located?

Above your straight-ahead eye level
At eye level
Below eye level

What is the distance from: Your eyes to the screen? ____________________
Your eyes to the keyboard? ____________________
Your eyes to your source documents? ____________________

Where is the computer screen located?
Directly in front of you when seated
To your right
To your left

Where are your source documents located?
Directly in front of you when seated
To your right
To your left
Flat (horizontal) or vertical

Do you experience any of the following lighting problems in your work area?
Glare from windows or other light sources
Reflections on your computer screen
Difficulty reading source documents

Do you wear glasses, contact lenses, or other optical devices for computer work?
Glasses
Contact lenses
Other (explain): ____________________

COMPUTERS (continued)
Please describe any problems you have with your vision, current glasses or contact lenses for computer work: ____________________
____
____

EMPLOYMENT OR SCHOOL
Current position: ____________________ Major course of study: ____________________
How many hours daily do you spend at a desk? ____________________
How many hours daily do you spend reading or studying? ____________________
How many hours daily do you spend working at near distances? ____________________
Do you feel you are achieving to your potential in work or school? Yes No
Do you feel you are getting adequate return for the amount of effort you put into a task? Yes No
If no, please explain: ____________________
Does your work or course of study demand comprehension from the written word? Yes No
Describe briefly your daily activities at work or in school: ____________________
____

HOBBIES/SPORTS
Describe the types of activities that comprise the majority of your leisure time: ____________________
____
____
Do you watch TV? Yes No

If yes, how many hours per day? ___________________________
How many days per week? ________________________________
Are you seriously involved with athletics? Yes No
Do you feel you are achieving up to your potential in sports/athletics? Yes No
Of all the sports you have played:
List the ones in which you excel: ____
List the ones in which you do poorly/avoid: ____

RELEASE OF INFORMATION AND INSURANCE FILING

It is often beneficial for us to discuss examination results and to exchange information with other professionals involved in your care. Please sign below to authorize the release of information.
I agree to permit information from, or copies of, my examination records to be exchanged with other health care providers or provided to insurance carriers upon their written request or upon the recommendation of the VISUALEYES OPTOMETRY. when it is necessary for the treatment of my visual condition, or for the processing of insurance claims. This authorization shall be valid for the duration of treatment.

____ _________

Signature or Authorized Representative Date

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation related to your specific visual needs.

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us.

You may leave a message for us 24 hours a day/7 days a week. We request a minimum of 24 hours notice if you are unable to keep this appointment.

Please be on time for your examination, so that we will have the maximum opportunity to evaluate your visual status. We are looking forward to meeting you.
Thank you.

Susan Kim-Laubach, O.D., F.C.O.V.D.
Clinical Director