

VISION REHABILITATION QUESTIONNAIRE*Please fill out this questionnaire carefully.***THANK YOU.**

Appointment: Day _____ Date _____ Time _____

Patient's Name: _____

GENERAL INFORMATIONPatient Name: _____ Male Female

Birth Date: _____ Age: _____

Home Address: _____

Home Phone: _____ Work Phone: _____

Marital status: Single Married Divorced Widowed 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

Primary Insurance: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

Social Security Number: _____ Driver's License No.: _____

What is your occupation? _____ Employer: _____

Business Address: _____

Spouse's Name: _____ Occupation: _____

Spouse's Employer: _____ Phone #: _____

Business Address: _____

MEDICAL HISTORY

Date of injury/accident: _____

Type of injury/accident: Motor vehicle Fall Blow to head Industrial Accident Medication-related Drug abuse Poison or toxic substance Carbon dioxide Drowning Cord around neck Stroke Aneurysm Hemorrhage

Other: _____

WHAT PART OF YOUR HEAD WAS AFFECTED? (check all that apply):

Forehead Right side Left side Back of head Top of head Face

Was the injury OPEN HEAD (bleeding) or CLOSED HEAD (non-bleeding)? _____

Did you lose consciousness? Yes No If yes, for how long? _____Were you in a coma? Yes No If yes, how long? _____

SYMPTOMS IMMEDIATELY FOLLOWING ACCIDENT/INJURY: (check all that apply)

Double vision Headache Blurred vision Pain in or around eyes Dizziness Vomiting Flashes of light Disorientation Loss of balance Neck pain/whiplash Loss of memory Restricted field of view Restricted motion

Other: _____

INITIAL TREATMENT

When did you first see a doctor regarding your accident/injury? _____
Name of Doctor: _____ Specialty: _____
Where were you seen? _____ Were you hospitalized? Yes No How long? ____
What were you and your family told? _____
What did the initial treatments consist of? _____
What prognosis/recommendations were you given? _____
Were you given medications? Yes No Medication: _____

For what condition(s)? _____
List any medications, including vitamins and supplements used at the current time: _____

SUBSEQUENT/OTHER PROFESSIONALCARE

WHAT TYPES OF PROFESSIONAL CARE HAVE YOU RECEIVED OR ARE YOU CURRENTLY RECEIVING? (check all that apply and describe):

Physicians Name: _____ Date: _____
Results and recommendations: _____
Physiatrist Name: _____ Date: _____
Results and recommendations: _____
Neurologist Name: _____ Date: _____
Results and recommendations: _____
Neuropsychologist Name: _____ Date: _____
Results and recommendations: _____
Physical Therapist Name: _____ Date: _____
Results and recommendations: _____
Speech / Language Therapist Name: _____ Date: _____
Results and recommendations: _____
Psychologist / Psychiatrist Name: _____ Date: _____
Results and recommendations: _____
Osteopathic Physicians Name: _____ Date: _____
Results and recommendations: _____
Other / Name: _____ Date: _____
Results and recommendations: _____

Do you have a history of allergies? Yes No

If yes, please explain: _____

Has a neurological evaluation been performed? Yes No

If yes, by whom? _____ Date: _____

Results: _____

Has a psychological evaluation been performed? Yes No

If yes, by whom? _____ Date: _____

Results: _____

Has a speech and language evaluation been performed? Yes No

If yes, by whom? _____ Date: _____

Results: _____

MEDICAL HISTORY

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

	<u>Patient</u>	<u>Family</u>	<u>Who</u>		<u>Patient</u>	<u>Family</u>	<u>Who</u>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>	_____	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Strabismus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brain Tumor	<input type="checkbox"/>	<input type="checkbox"/>	_____	Amblyopia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	Traumatic brain injury	<input type="checkbox"/>	<input type="checkbox"/>	_____

VISUAL HISTORY

Have you had a previous vision evaluation? Yes No

If yes, doctor's name: _____

Date of last evaluation: _____

Reason for examination: _____

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

If yes, what? _____

Are they used? Yes No If yes, when? _____

If no, why not? _____

Were any additional tests, treatments, or therapies recommended concerning your vision?

Yes No

If yes, what? _____

Did you undergo these treatments? Yes No Explain: _____

Results and recommendations: _____

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING:

	<u>Yes</u>	<u>No</u>	<u>Prior to Injury?</u>
Eyes ache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes pull or tug	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty moving or turning eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain with movement of eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes twitch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain in or around eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brightness is bothersome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motion sickness / car sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty changing focus far to near	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<u>Yes</u>	<u>No</u>	<u>Prior to Injury?</u>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
One eye turns in, out, up or down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Movement of objects in the environment is bothersome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fluorescent light is bothersome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patterned wallpaper or carpets are bothersome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head moves when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lose place often when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Words jump or move around when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short attention span for reading or writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skip words frequently when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discomfort when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of interest/concentration when doing close work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orient writing/drawing poorly on page	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squinting, covering or closing one eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head tilts during desk work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hold books too close	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoid reading or writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with peripheral vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Objects jump in and out of field of view	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reduced depth perception	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tunnel vision / Loss of visual field	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes of light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with bathing / personal hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty following a series of directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty using both sides of the body together	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dislike heights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Awkward, poor balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Confusion / disorientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get lost often	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bothered by noises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bothered by touch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty remembering things heard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty remembering things seen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty remembering name of objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty remembering people's names	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty recalling information known in the past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty remembering formerly familiar people / objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty performing tasks formerly easy / routine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Prior to

	<u>Yes</u>	<u>No</u>	<u>Injury?</u>
Difficulty with time management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with numbers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty counting money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Why do you feel the need for a vision evaluation today? _____

LIFESTYLE

Do you feel your vision interferes with activities of daily living? Yes No

If yes, please explain (please include effects involving home, work, hobbies social and personal relationships): _____

What activities comprise the majority of your daily life since your accident/injury? _____

What activities can you no longer engage in due to your visual or other difficulties? _____

What other changes/limitations in your daily life do you attribute to your accident/injury? _____

What do you hope a Visual Rehabilitation Program can do for you? _____

EMPLOYMENT/EDUCATION INFORMATION (IF APPLICABLE)

What is current employment position? _____

If a student, what is the major course of study? _____

How many hours daily are spent at a desk? _____

How many hours daily are spent working at near distance? _____

How many hours daily are spent reading/studying? _____

How many hours daily are spent with a computer? _____

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 this exchange of information.

I authorize the release of medical information to other health care providers or insurance carriers upon their written request, or upon the recommendation of Visualeyeyes Optometry when it is necessary for the treatment of my visual condition or for the processing of insurance claims. This authorization shall be considered valid for the duration of my treatment.

Signature of patient 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 and to better meet your specific visual needs.

If at any time you have any questions or concerns regarding your vision or treatment, please do not hesitate to contact us. You may leave a message for us 24 hours a day /7 day a week.

We request a minimum of 48 hours' notice if you are unable to keep this appointment.

Please be on time for your evaluation so that we may have the maximum opportunity to evaluate your visual status.

Please email this questionnaire to vt4fun@veoptometry.com or fax to (925) 463-7337 prior to your appointment

Thank you.

Visualeyeyes Optometry Staff