MEDICAL HISTORY QUESTIONNAIRE

Name: ____ Today's Date: _____ / _____ / _____
Address: ____ Phone: _________________________
City: ______________________ Postal Code: ________________ Alternate Phone: _________________
Guardian (if applicable): _________________________________ Occupation: _____________________
Birth Date: _____ / _____ / _____ Email: ____

General Medical History:

Please list all medication and environmental allergies: ____

Please list any diagnosed medical conditions you have:

____
____
____

Please list all medications you are taking (including oral contraceptives and aspirin):

____
____
____
____
____
____

Please list all vitamins or supplements you are taking:

____
____
____
____
____

Do you drink alcohol, smoke, or use any recreational drugs? ☐ NO ☐ YES
How often/much? ____

Please list all major injuries, surgeries, and/or hospitalizations you have had:

____
____
____

Are you pregnant or nursing? ☐ NO ☐ YES

Family History: Please note any family history (parents, grandparents, siblings, children, other blood relatives, living or deceased) for the following conditions:

Disease/Condition	NO	YES	UNSURE	Relationship to you
Blindness	☐	☐	☐	____
Glaucoma	☐	☐	☐	____
Macular Degeneration	☐	☐	☐	____
Retinal Detachment/Tear	☐	☐	☐	____
Retinal Disease	☐	☐	☐	____
Cancer	☐	☐	☐	____
Diabetes	☐	☐	☐	____
Heart Disease	☐	☐	☐	____
High Blood Pressure	☐	☐	☐	____
Kidney Disease	☐	☐	☐	____
Thyroid Disease	☐	☐	☐	____
Neurological condition	☐	☐	☐	____
Other: _______________	☐	☐	☐	____

Ocular History:

When was your last eye exam with an Optometrist or Ophthalmologist? ___________________________

Have you had any eye trauma or surgery? ☐ NO ☐ YES

If so, please describe and indicate when:

____

Have you been diagnosed with any eye condition(s)? ☐ NO ☐ YES

If so, please describe:

____

Do you wear glasses? ☐ NO ☐ YES

Do you wear contact lenses: ☐ NO ☐ YES

Type of contact lens (circle one): Rigid Soft Replacement: Monthly Daily Bi-Weekly Annually

Do you use over-the-counter or prescription eye drops? ☐ NO ☐ YES

If yes, please indicate name of drop(s) and frequency of use: ____________________________________

Traumatic Brain Injury History:

Date of injury / accident: ____

Type of injury / accident (circle all that apply):

Motor vehicle Stroke Fall Blow to head Industrial Accident Aneurysm

Medication-related Hemorrhage Drug abuse Poison or Toxic substance

Other: ____

What part of your head was affected? (circle 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? ☐ NO ☐ YES If yes, for how long? _______________________________

Were you in a coma? ☐ NO ☐ YES If yes, for how long? _______________________________

Have you had previous head injuries? ☐ NO ☐ YES If so, how many, and when?

____

SYMPTOMS IMMEDIATELY FOLLOWING THE INJURY: (check all that apply)

☐ Double vision	☐ Disorientation	☐ Loss of memory
☐ Headache	☐ Pain in or around the eyes	☐ Restricted field of view
☐ Dizziness	☐ Loss of balance	☐ Restricted motion
☐ Blurry vision	☐ Neck injury / Whiplash	☐ Vomiting

Other: ____

POST-INJURY CARE:

Has a neurological evaluation been performed? ☐ NO ☐ YES

If yes, by whom? ____Date: __________________

Has a psychological evaluation been perfomed? ☐ NO ☐ YES

If yes, by whom? ____Date: __________________

Has a vision/eye evaluation been perfomed? ☐ NO ☐ YES

If yes, by whom? ____Date: __________________

Please list any other professionals that have evaluated or are currently working with you (or your child) such as a: Physician, Psychologist/Psychiatrist, Physiatrist, Neurologist, Neuropsychologist, Physiotherapist, Occupational Therapist, Speech/Language Therapist, Tutor, or others. This list allows optimal communication with your medical team regarding your vision care.

Name	Profession	Clinic	Phone number	Frequency of visits (e.g. weekly)

CURRENT SYMPTOMS

Please check if you currently experience or experienced prior to injury, or whether the symptom doesn't apply:

	NO	YES	PRESENT PRIOR TO INJURY
Headaches	☐	☐	☐
Blurred vision	☐	☐	☐
Double vision	☐	☐	☐
Flashes of light	☐	☐	☐
Pain with eye movement	☐	☐	☐
Pain in or around eyes	☐	☐	☐
One eye turns in, out, up or down	☐	☐	☐
Difficulty moving or turning eyes	☐	☐	☐
Reduced depth perception	☐	☐	☐
Squinting, covering, or closing one eye	☐	☐	☐
Difficulty with peripheral vision	☐	☐	☐
Objects jump in and out of field of view	☐	☐	☐
Eye redness	☐	☐	☐
Eye burning	☐	☐	☐
Eye itching	☐	☐	☐
Eye watering	☐	☐	☐
Brightness is bothersome	☐	☐	☐
Fluorescent light is bothersome	☐	☐	☐
Difficulty seeing in dim lighting	☐	☐	☐
Patterned wallpaper or carpets are bothersome	☐	☐	☐
Movement of objects in environment is bothersome	☐	☐	☐
Motion sickness/car sickness	☐	☐	☐
Lose place/skip words often when reading	☐	☐	☐
Words jump or move around when reading	☐	☐	☐
Difficulty understanding what is read	☐	☐	☐
Discomfort/fatigue when reading	☐	☐	☐
Short attention span for close work	☐	☐	☐
Orient writing/drawing poorly on a page	☐	☐	☐
Dislike heights	☐	☐	☐
Awkward, poor balance	☐	☐	☐
Dizziness	☐	☐	☐
Confusion/disorientation	☐	☐	☐
Get lost often	☐	☐	☐
Difficulty dressing/bathing/personal hygiene	☐	☐	☐
Difficulty following a series of directions	☐	☐	☐
Difficulty using both sides of the body together	☐	☐	☐
Bothered by noises	☐	☐	☐
Bothered by touch	☐	☐	☐
Difficulty remembering things heard	☐	☐	☐
Difficulty remembering things seen	☐	☐	☐

	NO	YES	PRESENT PRIOR TO INJURY
Difficulty remembering name of objects	☐	☐	☐
Difficulty remembering people's names	☐	☐	☐
Difficulty recalling recent information	☐	☐	☐
Difficulty recalling information from the past	☐	☐	☐
Difficulty remembering formerly familiar people/objects	☐	☐	☐
Difficulty with time management	☐	☐	☐
Difficulty with numbers	☐	☐	☐
Get startled easily	☐	☐	☐
Gets emotional easily	☐	☐	☐
Experience blurred vision while walking/moving	☐	☐	☐

EMPLOYMENT / EDUCATION INFORMATION (IF APPLICABLE):

What was your employment position prior to injury? ____

What is your current employment position? ____

If currently working, what modifications have been implemented in your workplace since the injury?

____

____

____

Describe the visual demands of your job (e.g. many hours of computer work, safety glasses required, etc.)

____

____

____

For students:

What is the highest grade you completed in school? ____

How were your grades? ____

If post-secondary, what is the major course of study? ____

LIFESTYLE:

Do you feel your vision interferes with activities of daily living? ☐ NO ☐ YES

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

____

____

____

____

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

____

____

____

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

____
____
____
____

Release of Information:

Would you like copies of any reports? ☐ NO ☐ YES

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 give us permission to release information to the health care team as listed above.

Signed ____________________________________ Date: __________________________________

Thank you for carefully completing the 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.

We request a minimum of 24 hours notice if you are unable to keep this appointment.

Thank you,

Dr. Shirley Blanc and the staff at Bay St. Eyecare