MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Today's Date: _____/_____/_____
Address: _____ Phone: _____
City: _____ Postal Code: _____ Alternate Phone: _____
Guardian (if applicable): _____
Birth Date (mm/dd/year): ____/____/_____ Email: _____
Health Card Number: _____(___) Expiry Date: _____

GENERAL MEDICAL HISTORY:

Please list all **ALLERGIES** (including medications and environmental):

_____
_____
_____

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? □ NO □ YES If yes, how frequent? _____
Do you smoke? □ NO □ YES

Please list all major **SURGERIES or HOSPITALIZATIONS** you have had:

_____
_____
_____

Are you pregnant or nursing? □ NO □ YES

Any PRE-INJURY history of the following:

Attention Deficit Disorder	□ NO	□ YES
Anxiety	□ NO	□ YES
Depression	□ NO	□ YES
Learning Disability	□ NO	□ YES
Motion sickness	□ NO	□ YES
Migraine	□ NO	□ YES

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

Disease/Condition	NO	YES	Unsure	Relationship to you
Blindness	□	□	□	_____
Glaucoma	□	□	□	_____
Macular Degeneration	□	□	□	_____
Retinal Detachment/Tear	□	□	□	_____
Corneal transplant	□	□	□	_____

Other eye condition (please indicate): _____

Ocular History:

When was your last eye exam with an Optometrist or Ophthalmologist? _____
Have you had any eye trauma or surgery? □ NO □ YES
If YES, please describe and indicate when:

_____

Have you been diagnosed with any eye conditions? □ 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 / Annual
Do you use over-the counter or prescription eye drops? □ NO □ YES
If yes, please indicate NAME of drop and FREQUENCY of use: _____

Brain Injury History:

Date of injury / accident: _____
Describe the nature of the injury: _____

_____

_____

Was there direct injury to the head? □ NO □ YES
If yes, was the injury OPEN HEAD (bleeding) or CLOSED HEAD (non-bleeding)? (circle one)

Was there whiplash involved? □ NO □ YES
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 or WHIPLASH? □ NO □ YES
If so, list all previous injuries and when they occurred:

_____

_____

_____

CURRENT SYMPTOMS - QUESTIONNAIRE

Please indicate if you experience any of the following symptoms currently (ie. not symptoms that have completely resolved). All information will be held in confidence.

	None	Mild (1-2)		Moderate (3-4)		Severe (5-6)	
Headache	0	1	2	3	4	5	6
"Pressure in head"	0	1	2	3	4	5	6
Neck Pain	0	1	2	3	4	5	6
Nausea	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Blurred Vision	0	1	2	3	4	5	6
Balance Problems	0	1	2	3	4	5	6
Sensitivity to light	0	1	2	3	4	5	6
Sensitivity to noise	0	1	2	3	4	5	6
Feeling slowed down	0	1	2	3	4	5	6
Feeling like "in a fog"	0	1	2	3	4	5	6
"Don't feel right"	0	1	2	3	4	5	6
Difficulty concentrating	0	1	2	3	4	5	6
Difficulty remembering	0	1	2	3	4	5	6
Fatigue or low energy	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
More Emotional	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervous or Anxious	0	1	2	3	4	5	6
Trouble sleeping	0	1	2	3	4	5	6

Total number of symptoms: _____of 22
Total severity score: _____of 132
Do your symptoms get worse with mental activity? Y / N
If 100% is feeling like yourself, what % of your typical self do you feel? _____%

Do you experience difficulty with busy environments (eg. grocery stores)? ---------- Y / N
Do you experience difficulty with **scrolling** on a computer screen? ----------Y / N
Is it difficult for you to look at a computer screen (not scrolling)? ----------Y / N
Do you experience double vision? ----------Y / N
Are you sensitive to motion (objects moving in environment, eg. cars, sports games)? ---- Y / N
Do busy visual patterns bother you (stripes, busy rug patterns, etc.)? ---------- Y / N
Are you comfortable navigating through space? ---------- Y / N
Do you tend to bump into things? ---------- Y / N
Do you have problems with your peripheral vision? ---------- Y / N
Do you have symptoms when turning your head? ---------- Y / N
Do you have any of the following in the eyes: burning feeling, gritty feeling, watery, dry? Y / N

With **reading**, do you experience the following (CIRCLE all that apply):
Lose place Word movement/jumping Double vision Blurry vision Eyestrain
Headache Fatigue Cannot read for long periods Re-reading what was just read

Please list all other professionals that are currently working with you (or your child). This list allows communication with your medical team regarding your vision care.
(for example: General/Sports Medicine Physician, Neurologist/Neurosurgeon, Chiropractor, Osteopath, Physiotherapist, Occupational Therapist, Psychologist/Psychiatrist, Physiatrist, Neuropsychologist, Speech Language Therapist, Lawyer, etc.)

Name	**Profession**	**Clinic**	**Phone Number**	**Frequency of Visits (e.g. weekly)**

EMPLOYMENT/EDUCATION INFORMATION (IF APPLICABLE):

What was your employment position prior to the 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. how many hours of computer work, safety glasses requirements, 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 impact on work, home, hobbies, social, and personal relationships, as well as activities you can no longer engage in since the injury):

_____
_____
_____
_____
_____

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, and any other professionals you specify.

Signed _____ Date: _____

Thank you for taking the time and 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 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 staff