

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Tear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Corneal transplant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
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.

	<u>None</u>	<u>Mild (1-2)</u>		<u>Moderate (3-4)</u>		<u>Severe (5-6)</u>	
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)
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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