WHITBY VISION CARE

736 Dundas Street West, Whitby, Ontario L1N 2N4
reception@whitbyvision.ca • Tel: 905-666-4848 • Fax: 905-666-8160

HEAD INJURY/ABI PATIENT INFORMATION

Full Name: _____ Date of Birth (mm/dd/yy): _____

Home Address: _____ OHIP #: _____

City: _____ Postal Code: _____ Phone Number: _____

Emergency Contact: _____ Relationship: _____

Date of Injury: _____ Email Address: _____

How did you hear about us? _____

HEALTH HISTORY

Family Doctor: _____

Any Hospitalizations: _____

List of Medications: _____

_____

Do you have any allergies? ☐ Yes ☐ No

If so, please list them here: _____

_____

Please check the box if you have any history of the following:

☐ Glaucoma ☐ Cataracts
☐ Diabetes ☐ Heart Problems
☐ Retinal Detachment ☐ Macular Degeneration
☐ Colour Blindness ☐ Stroke
☐ Thyroid Condition ☐ Asthma
☐ Arthritis ☐ High Blood Pressure

Do any of the listed items above run in your family? If so, please list them here: _____

_____

_____

Do you have a valid driver's license? ☐ Yes ☐ No

Has your driver's license ever been suspended?

☐ Yes ☐ No

VISION/MVA RELATED QUESTIONS

Is this your first visual examination? ☐ Yes ☐ No

If not, when was your last examination? _____

Have you had any eye injuries in the past? ☐ Yes ☐ No

If so, please explain: _____

Have you had any eye surgeries? ☐ Yes ☐ No

If so, please explain: _____

Please check the box if you have experienced any of the following at the time of the MVA/ABI:

☐ Eye Injury ☐ CT scan ☐ MRI
☐ Closed head injury ☐ Whip lash ☐ Unconscious
☐ Cranial Sacral Therapy ☐ Chiropractic Therapy
☐ Physiotherapy

Please check the box if you get overwhelmed or anxious in any of the following situations:

☐ Big box stores ☐ Public transit ☐ Driving
☐ In large groups/ crowds ☐ Around loud noises

Do you work currently (part time or full time)? ☐ Yes ☐ No

If not, what barriers prevent you from working? _____

_____

_____

_____

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VISUAL SIGNS & SYMPTOMS

Please check the box if you have experienced any of the following since the time of the MVA/ABI:

- ☐ Dry eyes
- ☐ Watery eyes
- ☐ Eye drops
- ☐ Wandering eye
- ☐ Burning eyes
- ☐ Itchy eyes
- ☐ Eye turn
- ☐ Eye pain
- ☐ Rubbing eyes
- ☐ Flashes/spots in vision
- ☐ Squinting

Do you experience headaches? ☐ Yes ☐ No
If so, please explain: _____
_____

Reading

Please check the box if you have experienced any of the following since the time of the MVA/ABI:

- ☐ Lose place while reading
- ☐ Eye strain
- ☐ Hold closely to read
- ☐ Blur
- ☐ Skip or re-reads lines
- ☐ Headaches
- ☐ Print moves/jumps
- ☐ Double vision
- ☐ Falls asleep reading
- ☐ Dizziness
- ☐ Shuts one eye to read
- ☐ Nausea
- ☐ Trouble comprehending things I read

Average reading time prior to the MVA/ABI? _____
Average reading time after the MVA/ABI? _____

Hand-Eye Coordination

Please check the box if you have experienced any of the following since the time of the MVA/ABI:

- ☐ Poor hand writing/ printing
- ☐ Difficulty reaching for objects
- ☐ Reverses/ omits letters
- ☐ Difficulty catching balls

Please describe your hand-eye coordination: _____
_____

Distance Vision

Please check the box if you have experienced any of the following since the time of the MVA/ABI:

- ☐ Eye strain
- ☐ Double vision distance
- ☐ Trouble judging distance
- ☐ Blur distance
- ☐ Vehicles appear in wrong lane

Lighting

Please check the box if you have experienced any of the following since the time of the MVA/ABI:

- ☐ Light sensitivity indoors
- ☐ Glare of lights at night
- ☐ Light sensitivity in sunlight
- ☐ Trouble seeing in dark areas
- ☐ Light induces headache

Walking

Please check the box if you have experienced any of the following since the time of the MVA/ABI:

- ☐ Bumps into things/people
- ☐ Nausea while moving
- ☐ Trips over objects/curb
- ☐ Dizziness
- ☐ Lose balance while walking
- ☐ Ground does not appear level
- ☐ Need assistive device while walking (cane, walker,etc)

Standing/Sitting

Please check the box if you have experienced any of the following since the time of the MVA/ABI:

- ☐ Feeling dizzy while still
- ☐ Objects move while still
- ☐ Nausea while sitting
- ☐ Lose balance easily
- ☐ Nausea while standing
- ☐ Incomplete image of objects
- ☐ Seeing objects or things that are not really there

Other

Please check the box if you have experienced any of the following since the time of the MVA/ABI:

- ☐ Loses belongings
- ☐ Poor concentration
- ☐ Easily distracted
- ☐ Poor memory/forgetful
- ☐ Dizzy while traveling (car)
- ☐ Nausea while traveling (car)
- ☐ Trouble comprehending things I see
- ☐ Trouble comprehending what I hear

If you have any specific comments or questions for the doctor please list them here: _____
_____
_____
_____
_____