BRIER CREEK VISION CARE & THE CENTER FOR VISUAL LEARNING & REHABILITATIVE THERAPY
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ADULT VISION AND MEDICAL HISTORY QUESTIONNAIRE

Please complete this questionnaire carefully and return it to our office as soon as possible.

GENERAL INFORMATION

Patient's Full Name: _____ Male ☐ Female ☐

Birth Date: _____ Age: _____ Occupation: _____

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

Were you referred to our office? Yes ☐ No ☐ If yes, by whom: _____

MEDICAL HISTORY

Physician's Name/Practice Name:_____ Date of Last Evaluation: _____

Current medications and reasons for taking them (including vitamins and supplements): _____

_____

_____

Drug allergies: _____

Do you currently smoke or use tobacco products? None ☐ Cigarettes ☐ Cigars ☐

Vape ☐ Smokeless/chewable tobacco ☐

If yes, years of use: _____ If cigarettes, # packs smoked/day: _____

If no, have you ever been a tobacco user? Yes ☐ No ☐ If yes, how many years? _____

Year quit: _____

Alcohol use: None ☐ Social ☐ 1-2 drinks/day ☐ Above average ☐ Alcohol dependence ☐

Narcotic drug use: None ☐ Recreational use ☐ Chemical dependence ☐

MEDICAL HISTORY:

	Patient	**Family**	**Relation/Details**
High blood pressure	☐	☐	_____
Heart disease	☐	☐	_____
High cholesterol	☐	☐	_____
Stroke	☐	☐	_____
Diabetes/Endocrine	☐	☐	_____
Blood/lymphatic	☐	☐	_____
Arthritis	☐	☐	_____
Cancer (type)	☐	☐	_____
Thyroid Disease	☐	☐	_____
Lung Disease (asthma/emphysema)	☐	☐	_____
Ear, nose, throat (allergies)	☐	NA	_____

	Patient	Family	Relation/Details
GI disease (ulcers/acid reflux)	☐	NA	_____
Kidney, Bladder, Genital	☐	NA	_____
Neurological	☐	NA	_____
Acquired/Traumatic Brain Injury	☐	NA	_____
Depression	☐	NA	_____
Anxiety	☐	NA	_____
Infectious disease (HIV/hepatitis)	☐	NA	_____

Surgeries (list): _____

Please answer the following questions if you are a female:
Are you pregnant? Yes ☐ No ☐ If yes, due date: _____
Are you currently breastfeeding? Yes ☐ No ☐

OCULAR HISTORY

	Patient	Family	Relation/Details
Glaucoma	☐	☐	_____
Cataracts	☐	☐	_____
Macular degeneration	☐	☐	_____
Retinal disorders	☐	☐	_____
Blindness	☐	☐	_____
Strabismus/eye turn	☐	☐	_____
Amblyopia/lazy eye	☐	☐	_____
Eye injuries	☐	NA	_____
Eye surgeries	☐	NA	_____

Others (list): _____

VISUAL HISTORY

Why do you feel you need a vision examination? _____

_____

Have you had a previous vision evaluation? Yes ☐ No ☐

If yes, Doctor's name: _____ Date of last evaluation: _____

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

If yes: Single vision ☐ Lined bifocal ☐ No-line bifocal ☐ Contact lenses ☐

Are they worn? Yes ☐ No ☐ If yes, when? If no, why not? _____

_____

If wearing contact lenses, what type are they? Soft ☐ Rigid Gas Permeable/Hard ☐

If soft, brand and power: _____

If soft, how frequently are lenses replaced? _____

What solutions are used? _____

How many days per week do you wear contacts, on average? _____

How many years have you worn contact lenses? _____

Are there any problems with current optical prescription? Yes ☐ No ☐

If yes, explain: _____

Were any additional tests, treatments, or therapies recommended? Yes ☐ No ☐

If yes, what? _____

Did you undergo these treatments? Yes ☐ No ☐ Explain: _____

Results and recommendations: _____

Do you experience any of the following:	**Yes**	**No**	**If yes, when?**
Difficulty seeing distance objects	☐	☐	_____
Difficulty with near vision	☐	☐	_____
Frequent styes	☐	☐	_____
Red or bloodshot eyes	☐	☐	_____
Eyes water	☐	☐	_____
Eyes itch	☐	☐	_____
Eyes burn	☐	☐	_____
Dry eyes	☐	☐	_____
Bothered by light	☐	☐	_____
Floaters in your vision	☐	☐	_____
Flashes of light	☐	☐	_____
Fatigue with reading/computer/close work	☐	☐	_____
Avoid reading	☐	☐	_____
Letters/words run together/move when reading	☐	☐	_____
Loss of place when reading	☐	☐	_____
Need finger to keep place when reading	☐	☐	_____
Comprehension decreases over time	☐	☐	_____
Headaches	☐	☐	_____
Double vision	☐	☐	_____
Close/cover one eye to see better	☐	☐	_____
Eye turns in/out/up/down	☐	☐	_____
Motion sickness / car sickness	☐	☐	_____

Are you experiencing any of the following symptoms associated with computer use:
Eye strain Yes ☐ No ☐
Dry eyes Yes ☐ No ☐
Headaches Yes ☐ No ☐
Blurred vision Yes ☐ No ☐
Does the glare of the computer screen bother your eyes? Yes ☐ No ☐
How many hours per day do you use a computer? _____
Typical working distance from computer monitor: _____
Typical working distance from reading material: _____

Do you feel your vision hinders your daily activities in any way? Yes ☐ No ☐

If yes, please explain: _____

_____

Is there any other information that you feel would be helpful/important for our evaluation?

_____

_____

_____

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 ***Brier Creek Vision Care*** 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. I consent that typing my name below will act as my signature.

_____ _____

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 better meet your specific visual needs.

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us. We request a minimum of 24 hour notice if you are unable to keep this appointment.

Missed appointment fee is $75 without 24 hour notice.

Please be on time for your examination, so that we will have the maximum opportunity to evaluate your visual status.

Thank you.

The Staff of Brier Creek Vision Care & The Center for Visual Learning & Rehabilitative Therapy