

ADULT STRABISMUS 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:

	<u>Patient</u>	<u>Family</u>	<u>Relation/Details</u>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes/Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood/lymphatic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer (type)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Disease (asthma/emphysema)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear, nose, throat (allergies)	<input type="checkbox"/>	NA	_____

	<u>Patient</u>	<u>Family</u>	<u>Relation/Details</u>
GI disease (ulcers/acid reflux)	<input type="checkbox"/>	NA	_____
Kidney, Bladder, Genital	<input type="checkbox"/>	NA	_____
Neurological	<input type="checkbox"/>	NA	_____
Acquired/Traumatic Brain Injury	<input type="checkbox"/>	NA	_____
Depression	<input type="checkbox"/>	NA	_____
Anxiety	<input type="checkbox"/>	NA	_____
Infectious disease (HIV/hepatitis)	<input type="checkbox"/>	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

	<u>Patient</u>	<u>Family</u>	<u>Relation/Details</u>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Strabismus/eye turn	<input type="checkbox"/>	<input type="checkbox"/>	_____
Amblyopia/lazy eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye injuries	<input type="checkbox"/>	NA	_____
Eye surgeries	<input type="checkbox"/>	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: _____

At what age was it first noticed or suspected that an eye was turning? _____

Was there any related trauma, disease, or condition that preceded or accompanied the onset of the eye turn? Yes No If yes, please explain: _____

Did the eye begin turning suddenly or gradually? _____

Does the eye turn (check all that apply): In Out Up Down

Is the eye turn: Worsening Improving Stable

Is it always the same eye that turns? Yes No If yes, which eye? Right Left

Is the eye turn always present? Yes No

If no, under what conditions is it present? _____

Has amblyopia (lazy eye) been diagnosed? Yes No

Has there been any treatment using an eye patch? Yes No

If yes, please specify which eye was patched, age patching was initiated, duration of treatment and results: _____

Has there been any surgical treatment? Yes No

If yes, please list the age surgery was performed, the number of operations, the eye(s) on which surgery was performed: _____

Were the results of the surgery satisfactory? Yes No Explain: _____

Have surgical results been maintained? Yes No Explain: _____

Has there been any vision therapy? Yes No

If yes, list dates of vision therapy and doctor's name: _____

Results of therapy: _____

Is this appointment for a second opinion on surgery or other forms of treatment? Yes No

Do you experience any of the following:

Yes **No**

If yes, when?

Difficulty seeing distance objects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty with near vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent styes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Red or bloodshot eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes water	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes itch	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes burn	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bothered by light	<input type="checkbox"/>	<input type="checkbox"/>	_____
Floaters in your vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flashes of light	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fatigue with reading/computer/close work	<input type="checkbox"/>	<input type="checkbox"/>	_____
Avoid reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Letters/words run together/move when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of place when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Need finger to keep place when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Comprehension decreases over time	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Close/cover one eye to see better	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye turns in/out/up/down	<input type="checkbox"/>	<input type="checkbox"/>	_____
Motion sickness / car sickness	<input type="checkbox"/>	<input type="checkbox"/>	_____

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