

VISION REHABILITATION 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

Date of injury/accident: _____
Type of injury/accident: Motor vehicle Fall Blow to head Industrial accident
Medication-related Drug abuse Poison or toxic substance Carbon dioxide
Drowning Cord around neck Stroke Aneurysm Hemorrhage
Other: _____

What part of your head was affected (check all that apply):
Forehead Right side Left side Back of head Top of head Face
Was the injury OPEN HEAD (bleeding) or CLOSED HEAD (non-bleeding)? _____
Did you lose consciousness? Yes No If yes, for how long? _____
Were you in a coma? Yes No If yes, how long? _____

INITIAL TREATMENT

Did the injury/accident require you to immediately go to the Emergency Department? Yes No
If yes, were you admitted? Yes No If yes, how long? _____
If no, when did you seek medical care? _____
What were you and your family told? _____
What prognosis/recommendations were you given? _____

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

Drug allergies: _____

PROFESSIONAL CARE

What types of professional care have you received or are you currently receiving?

Primary Care Practitioner: _____ Date of last visit: _____

Physiatrist: _____ Date of last visit: _____

Neurologist: _____ Date of last visit: _____

Neuro-psychologist: _____ Date of last visit: _____

Occupational Therapist: _____ Date of last visit: _____

Physical Therapist: _____ Date of last visit: _____

Speech/Language Therapist: _____ Date of last visit: _____

Psychologist/Psychiatrist: _____ Date of last visit: _____

Other: _____ Date of last visit: _____

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	_____
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): _____			

SOCIAL HISTORY

Marital Status: Single Married Divorced Widowed

Do you live alone? Yes No Nursing Home

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

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: _____

LIFESTYLE

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

If yes, please explain: _____

What activities can you no longer engage in due to your visual or other difficulties?

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: _____

Is there any other information that you feel would be helpful/important in our evaluation and/or treatment? Yes No If yes, explain: _____

SYMPTOM CHECKLIST

<u>Please circle the number that best matches your observations.</u>	Never	Seldom	Occasionally	Frequently	Always
Distance vision is blurry (even with glasses)	0	1	2	3	4
Near vision is blurry (even with glasses)	0	1	2	3	4
Difficulty changing focus from one distance to another	0	1	2	3	4
Eye discomfort / Eyestrain	0	1	2	3	4
Pain with movement of eyes	0	1	2	3	4
Fluorescent / artificial light is bothersome	0	1	2	3	4
Sunlight is exceptionally bothersome	0	1	2	3	4
Headaches	0	1	2	3	4
Double vision	0	1	2	3	4
Close / cover one eye to see better	0	1	2	3	4
Tilt / turn head to one side excessively	0	1	2	3	4
Fatigue quickly when reading	0	1	2	3	4
Lose place when reading	0	1	2	3	4
Words jump or move around when reading	0	1	2	3	4
Print moves in and out of focus when reading	0	1	2	3	4
Difficulty with peripheral / side vision	0	1	2	3	4
Clumsy / bumps into things	0	1	2	3	4
Bothered by busy, crowded environments	0	1	2	3	4
Patterned carpets / wallpaper are bothersome	0	1	2	3	4
Motion sensitivity	0	1	2	3	4
Car sickness	0	1	2	3	4
Misjudge where objects really are	0	1	2	3	4
Awkward / poor balance	0	1	2	3	4
Dizziness	0	1	2	3	4
Prone to falls	0	1	2	3	4

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