Advanced Family Eyecare

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VISION REHABILITATION QUESTIONAIRE

Please fill out this questionnaire carefully and return it to our office via website, mail, email or fax prior to your appointment.

Appointment: Day ____________________ Date ____________________ Time ____________________

Patient's Name: ____

GENERAL INFORMATION

Patient Name: ____ ❑ Male ❑ Female

Birth Date: ________________ Age: ____________ Social Security Number: ____________________

Home Address: ____

Home Phone: ____________________ Cell Phone: ________________ Work Phone: ____________

Email Address: ____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Legally Separated ❑ Widowed

Race: ❑ White ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Hispanic ❑ Native Hawaiian/ other Pacific Island

Ethnicity: ❑ Not Hispanic or Latino ❑ Hispanic or Latino ❑ Native Hawaiian/other Pacific Island

Preferred Language: ❑ English ❑ Spanish

What is your occupation: __________________________ Employer: __________________________

Business Address: ____

Spouse's Name: __________________________ Occupation: __________________________

Spouse's Employer: __________________________ Phone: __________________________

Business Address: ____

If referred, who referred you? ____

May we use your name in thanking them? ❑ Y ❑ N

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?____________________

Symptoms immediately following injury: (check all that apply)

❑ Double vision ❑ Headache ❑ Blurred vision ❑ Pain in or around eyes ❑ Dizziness ❑ Vomiting ❑ Flashes of light ❑ Disorientation ❑ Loss of balance ❑ Neck pain/whiplash ❑ Loss of memory ❑ Restricted field of view ❑ Restricted motion ❑ Other: ____

INITIAL TREATMENT

When did you first see a doctor regarding your accident/injury? ____________________

Name of doctor: ____________________ Specialty: ____________________

Where were you seen? ____________________ Were you hospitalized? ❑ No ❑ Yes, how long? ____________________

What were you and your family told? ____________________

What did the initial treatments consist of? ____________________

What prognosis/recommendations were you given? ____________________

Were you given medications? ❑ No ❑ Yes, list medication and indicate for what condition(s): ____________________

____

List any medications, including vitamins and supplements used at the current time: ____________________

____

SUBSEQUENT CARE/OTHER PROFESSIONAL CARE

What types of professional care have you received or are you currently receiving? (check all that apply and describe)

❑ Physician - Name: ____________________ Date: ____________________

Results and recommendations: ____________________

❑ Neurologist - Name: ____________________ Date: ____________________

Results and recommendations: ____________________

❑ Neuropsychologist - Name: ____________________ Date: ____________________

Results and recommendations: ____________________

❑ Physical Therapist - Name: ____________________ Date: ____________________

Results and recommendations: ____________________

❑ Speech/Language Therapist - Name: ____________________ Date: ____________________

Results and recommendations: ____________________

❑ Psychologist/Psychiatrist - Name: ____________________ Date: ____________________

Results and recommendations: ____________________

❑ Osteopathic Physician - Name: ____________________ Date: ____________________

Results and recommendations: ____________________

❑ Other - Name: ____________________ Date: ____________________

Results and recommendations: ____________________

Do you have a history of allergies? ❑ Yes ❑ No

If yes, please explain: ____________________

Has a neurological evaluation been performed? ❑ Yes ❑ No

If yes, by whom? ____________________ Date: ____________________

Results: ____________________

Has a psychological evaluation been performed? ❑ Yes ❑ No

If yes, by whom? ____________________ Date: ____________________

Results: ____________________

Has a speech and language evaluation been performed? ❑ Yes ❑ No

If yes, by whom? ____________________ Date: ____________________

Results: ____________________

MEDICAL HISTORY

Is there any history of the following? (please check if there is a history)

Condition				Condition			
High Blood Pressure -	❑ Patient	❑ Family:	______	Glaucoma	❑ Patient	❑ Family:	______
Diabetes	❑ Patient	❑ Family:	______	Cataracts	❑ Patient	❑ Family:	______
Thyroid Condition	❑ Patient	❑ Family:	______	Blindness	❑ Patient	❑ Family:	______
Multiple Sclerosis	❑ Patient	❑ Family:	______	Strabismus	❑ Patient	❑ Family:	______
Brain Tumor	❑ Patient	❑ Family:	______	Amblyopia	❑ Patient	❑ Family:	______
Traumatic Brian Injury	❑ Patient	❑ Family:	______	Stroke	❑ Patient	❑ Family:	______

VISUAL HISTORY

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

If yes, doctor's name: ______________________________

Date of last evaluation: ______________

Reason for examination: ______________________________

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

If yes, what? ______________________________

Are they used? ❑ Yes ❑ No If yes, when? ______________________________

If no, why not? ______________________________

Where any additional tests treatments or therapies recommended concerning your vision? ❑ Yes ❑ No

If yes, what? ______________________________

Did you undergo these treatments? ❑ Yes ❑ No Explain: ______________________________

Results and recommendations: ______________________________

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING:

	Yes	No	Prior to Injury?
Eyes ache……	❑	❑	❑
Eyes pull or drag ……	❑	❑	❑
Difficulty moving or turning eye ……	❑	❑	❑
Pain with movement of eyes……	❑	❑	❑
Eyes twitch……	❑	❑	❑
Pain in or around eyes……	❑	❑	❑
Eye redness……	❑	❑	❑
Burning eyes……	❑	❑	❑
Watery eyes……	❑	❑	❑
Itchy eyes……	❑	❑	❑
Brightness is bothersome……	❑	❑	❑
Motion sickness/car sickness……	❑	❑	❑
Headaches……	❑	❑	❑
Blurred vision……	❑	❑	❑
Double vision ……	❑	❑	❑
One eye turns in, out, up or down ……	❑	❑	❑
Movement of objects in the environment is bothersome ……	❑	❑	❑
Fluorescent light is bothersome ……	❑	❑	❑
Patterned wallpaper or carpets are bothersome ……	❑	❑	❑
Head moves when reading ……	❑	❑	❑
Lose place often when reading ……	❑	❑	❑
Words jump or move around when reading ……	❑	❑	❑
Short attention span for reading or writing ……	❑	❑	❑

Skip words frequently when reading…..	❑	❑	❑
Discomfort when reading …………………..	❑	❑	❑
Loss of interest/concentration doing close work …………………..	❑	❑	❑
Orient writing/drawing poorly on page..	❑	❑	❑
Squinting, covering or closing one eye….	❑	❑	❑
Head tilts during desk work………………..	❑	❑	❑
Hold books too close ………………………..	❑	❑	❑
Avoid reading or writing …………………..	❑	❑	❑
Difficulty with peripheral vision………...	❑	❑	❑
Objects jump in and out of field view…...	❑	❑	❑
Reduced depth perception ………………..	❑	❑	❑
Tunnel vision/ Loss of visual field ………...	❑	❑	❑
Flashes of light ………………………………...	❑	❑	❑
Difficulty with dressing ……………………..	❑	❑	❑
Difficulty with bathing/personal hygiene	❑	❑	❑
Difficulty following a series of directions	❑	❑	❑
Difficulty using both sides of the body together ……………………………...	❑	❑	❑
Dislikes heights ……………………………....	❑	❑	❑
Awkward, poor balance ……………………..	❑	❑	❑
Dizziness ………………………………………..	❑	❑	❑
Confusion/disorientation …………………..	❑	❑	❑
Get lost often …………………………………..	❑	❑	❑
Bothered by noises …………………………..	❑	❑	❑
Bothered by touch …………………………...	❑	❑	❑
Difficulty remembering things heard …...	❑	❑	❑
Difficulty remembering things seen ……...	❑	❑	❑
Difficulty remembering names of objects	❑	❑	❑
Difficulty remembering people's names ..	❑	❑	❑
Difficulty recalling information known in the past …………………………...	❑	❑	❑
Difficulty remembering formerly familiar people/objects …………...	❑	❑	❑
Difficulty performing tasks formerly easy/routine ……………………..	❑	❑	❑
Difficulty with time management ………...	❑	❑	❑
Difficulty with numbers …………………....	❑	❑	❑
Difficulty counting numbers ……………...	❑	❑	❑

Why do you feel you need a vision evaluation today?

____

____

____

LIFESTYLE

Do you feel your vision interferes with activities of daily living? ❑ Yes ❑ No

If yes, please explain (please include effects involving home, work, hobbies, social relationships and personal relationships):

____

____

____

What activities comprise the majority of your daily life since your accident/injury? ____________________________
____
____
____

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

What other changes/limitations in your daily life do you attribute to your accident/injury? ______________________
____
____
____

What do you hope a Visual Rehabilitation Program can do for you? _______________________________________
____
____
____

EMPLOYMENT/EDUCATION INFORMATION (if applicable)

What is your current employment position? ____
If a student, what is the major course of study? ____
How many hours daily are spent at a desk? ____
How many hours daily are spent working at near distance? ______________________________________
How many hours daily are spent reading/studying? ____
How many hours daily are spent with a computer? ____

RELEASE OF INFORMATION

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 the Advanced Family Eyecare when it is necessary for the treatment of my visual condition. This authorization shall be considered valid for the duration of my treatment.

Signature of authorized patient or 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 perform a more comprehensive evaluation and to better meet your specific visual needs.

If at any time you have any questions or concerns regarding your vision or treatment, please do not hesitate to contact us. You may leave a message for us 24 hours a day, 7 days a week.

Please request a minimum of 24 hours notice if you are unable to keep this appointment.

Please be on time for your evaluation so that we may have the maximum opportunity to evaluate your visual status.

Thank you.

Sincerely,

Samuel C. Oliphant, O.D., F.A.A.O.
Jennifer L. Brooks, O.D.