

Welcome To Our Office!

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Birth Date _____ Email Address _____ Referred by _____
Other Family Members at home (include ages and relationships)

Chief Complaints:

What is your major problem or concern? _____

Are you presently experiencing any of the following? (Please check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Difficulty in depth perception |
| <input type="checkbox"/> Burning of the eyes | <input type="checkbox"/> Difficulty with driving |
| <input type="checkbox"/> Watering/tearing of the eyes | <input type="checkbox"/> Difficulty in sports performance |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Visual discomfort while using computer |
| <input type="checkbox"/> Redness of the eyes | <input type="checkbox"/> Slow reading |
| <input type="checkbox"/> Light sensitivity | <input type="checkbox"/> Difficulty in reading comprehension |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Lose place while reading |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Short attention span in visual tasks |
| <input type="checkbox"/> Eye(s) turn in, out, up or down | <input type="checkbox"/> Clumsiness/bumping into things |
| <input type="checkbox"/> Flashes of light | <input type="checkbox"/> Sleepy/tired when doing visual work |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Backaches or neck aches |
| <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Posture problems |

Other _____

Visual History:

Have you had a previous visual exam? If so, when? _____ With dilation? _____

Doctor's Name _____ Diagnosis/Recommendations _____

Were glasses prescribed? _____ Do you wear them now? _____ For what? _____

Do you wear contact lenses? _____ What kind? _____

Have you ever had vision therapy? _____ When? _____

Have you ever had an injury to or surgery on your eyes? _____ If so, when? _____

Medical History:

Are you presently experiencing any of the following? (please check)

- | | | |
|--|------------------------------------|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Other: _____ |

Is there any family history of these conditions? _____ If so, which? _____

Physician's name _____ Address _____

Date of last exam _____ Please list any medications you are taking _____

Have you ever suffered a head or brain injury? _____ If yes, please explain _____

Visual Demands:

Type of Occupation/School _____ Visual Demands- Near _____ Far _____ Other _____

Computer use per day _____

Are there any special visual demands you have at work, home or play? _____

Please list any other information you think may help us to understand your visual needs _____
