ADULT'S VISION QUESTIONNAIRE

Please fill out this questionnaire carefully and return it to our office at the time of your scheduled vision therapy evaluation appointment.

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Gender: □Male □Female Email Address: _____

Home Phone: _____ Cell Phone: _____

_____ _____, _____ _____

Street Address City State Zip Code

Occupation: _____

PRESENT SITUATION

Were you referred to our office? □Yes □No

If yes, by whom? _____

Chief Complaint/Reason for the Visit: _____

At which age did you notice the problem? _____

Has the problem become: □Better □Worse □Stayed the Same

Has there been any previous treatment?: □Yes □No

If yes, please describe:

_____

Date of last eye examination: _____

ADDITIONAL TESTING HISTORY

Educational: □Yes □No If yes, what were the results?: _____

Hearing: □Yes □No If yes, what were the results?: _____

Neurological: □Yes □No If yes, what were the results?: _____

Psychological: □Yes □No If yes, what were the results?: _____

Speech: □Yes □No If yes, what were the results?:

_____

OT/PT: □Yes □No If yes, what were the results?:

_____

MEDICAL HISTORY

Primary Care Doctor:

_____

_____ _____, _____

_____

Street Address City State

Zip Code

Last Visit Date: _____

Reason for Visit:

_____

MEDICAL HISTORY (continued)

Have you been diagnosed with or treated with the following health problems? If yes, please describe:

□ Cancer:

_____

□ Digestive/Gastrointestinal:

_____

□ Ear/Nose/Throat:

_____

□ Genitourinary:

_____

□ Neuro/Traumatic Brain Injury:

_____

□ Muscle/Bone/Arthritis:

_____

□ Psych/Behavioral:

_____

□ Skin Conditions/Disorders:

_____

□ Cardio/High Blood Pressure/Cholesterol:

_____

□ Diabetes/Thyroid/Endocrine:

_____

□ Respiratory/Asthma:

_____

□ Immune/Allergies: _____

Are you taking any medications? □Yes □No
If yes, which medications and what dosage?:
_____
_____
____
Do you have any known allergies? □Yes □No
If yes, please describe?:
_____
_____
____

FAMILY HISTORY
Does anyone in your family have any of the following health problems? If yes, who?
□ Cancer: _____
□ Diabetes: _____
□ Hypertension: _____
□ Hyperthyroidism: _____
□ Hypothyroidism: _____
□ Cataracts: _____
□ Macular Degeneration: _____
□ Glaucoma: _____

SOCIAL HISTORY
Do you smoke? □Yes □No If yes, for how long?: _____
Do you drink alcohol? □Yes □No If yes, how many drinks per day?: _____

HEAD INJURY HISTORY
Have you had any kind of head injury?: □Yes □No
If yes, please describe (when, how did it happen, etc.):
_____

___Were you hospitalized? □Yes □No

VISUAL SYMPTOMS

College of Optometrists in Vision Development (COVD) Symptom List	Never	Seldom	Occasionally	Frequently	Always
Blurred close vision					
Double vision					
Headaches with near work					
Words run together while reading					
Burning, itchy, watery eyes					
Falls asleep while reading					
Sees worse at the end of the day					
Skips/repeats lines while reading					
Dizzy/nauseated by near work					
Head tilt/one eye closed to read					
Difficulty copying from the board					
Avoids near work/reading					
Omits small words when reading					
Writes uphill/downhill					
Misaligns digits/columns of numbers					
Poor reading comprehension					
Poor/inconsistent in sports					
Holds reading too close					

Trouble keeping attention on reading					
Difficulty completing work on time					
Says “I can’t” before trying					
Avoids sports/games					
Poor hand/eye coordination					
Poor handwriting					
Does not judge distance accurately					
Clumsy, knocks things over					
Poor time use/management					
Does not make change well					
Loses things/belongings					
Car or motion sickness					
Forgetfulness/poor memory					

VISUAL SYMPTOMS (continued)
Have the following vision problems been diagnosed?:
Amblyopia (lazy eye): □Yes □No
If yes, was there any treatment for the Amblyopia?: □Yes □No
If yes, describe treatment:
_____
___
Strabismus (eye turn): □Yes □No
If yes, at what age was the eye turn first noticed? _____
Did the eye turn start: □Suddenly □Gradually
Which direction does the eye turn? (check all that apply): □In □Out □Up □Down
Which eye turns?: □Left □Right □Both
When does the eye turn? (check all that apply):
□Always □Rarely □Beginning of the Day □End of the Day □When Tired
Have you had any treatment for the strabismus? □Yes □No
If yes, describe treatment:

_____

_____

ACTIVITIES

(Check the sports or athletic activities you actively participate in)

☐ Archery	☐ Baseball	☐ Basketball	☐ Cheerleading
☐ Equestrian	☐ Football	☐ Golf	☐ Gymnastics
☐ Ice Hockey	☐ Lacrosse	☐ Martial Arts	☐ Skating
☐ Skiing	☐ Soccer	☐ Softball	☐ Swimming
☐ Tennis	☐ Track and Field	☐ Volleyball	☐ Wrestling

Please list any hobbies or special interests:

_____

_____

Thank you for taking the time to fill this information out prior to your visit.
We look forward to meeting with you.

For in-office use only:

Information reviewed by staff member: _____ Date: _____