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WELCOME TO OUR OFFICE

Our office is dedicated to servicing our patients with the highest quality of vision care. We use continuing educating to remain at the forefront of our profession and offer the latest eye care technology, professional services and products, we believe that our patients are our friends and that our relationship can last a lifetime.

VISION REHABILITATION QUESTIONNAIRE

Please fill out this form carefully and return it one week before your appointment.

Today's Date: ______________________ Home Phone: (   ) ______________________

Work Phone: (   ) ______________________ Cell Phone: (   ) ______________________

O Mr. O Mrs. O Miss O Ms O Child Email Address ______________________

Patient's Name: ______________________ Nick Name: ______________________

Address: ______________________ City ______________ State ________ Zip ________

Birthday: ______________________ Parent(s) / Guardian (If a child) ______________________

O Siblings (if a child) ______________________

Patient's Occupation: ______________________

Employer: ______________________

Primary Medical Insurance: ______________________ ID# ______________________

Vision Insurance: ______________________ ID# ______________________

Social Security # ______________________ Driver's License # ______________________

Primary Care Doctor: ______________________ Office Phone: ______________________

Insured's Name (if different form patient) ______________________ ID# ______________________

Insured's Birthday: ______________________ Insured's Employer ______________________

Who can we thank for referring you to our office? ______________________

O Friend O Doctor O Relative O School O Yellow Pages O Other ______________________

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Escondidopremiereyecare.com

A. MEDICAL HISTORY

Date of injury / accident: ____________________

Type of injury / accident: ____________________

Motor Vehicle O Stroke O Fall O Blow to head O Industrial Accident O
Medication-related O Drug abuse O Poison or toxic substance O Carbon dioxide O
Drowning O Cord around neck O Aneurysm O Hemorrhage O

Other: ____________________

WHAT PART OF YOUR HEAD WAS AFFECTED? (check all that apply):

Forehead O Right Side O Left O Back of head O Top of head O Face O

Was the injury OPEN HEAD (bleeding) or CLOSED HEAD (non-bleeding)? ____________________

Did you lose consciousness? Yes O NO O If yes, for how long? ____________________

Were you in a coma? Yes O No O If Yes , how long? ____________________

SYMPTOMS IMMEDIATELY FOLLOWING ACCIDENT / INJURY: (check that apply)

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

Other: ____________________

INTIAL TREATMENT

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

Name of Doctor: ____________________ Specialty: ____________________

Where were you seen? ____________________ Were you hospitalized? Yes O No O How long O ___

What were you and your family told? ____________________

What did the initial treatments consist of? ____________________

What prognosis/recommendations were you given? ____________________

Were you given medications? Yes O No O Medication: ____________________

____

For what condition(s)? ____________________

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

____

SUBSEQUENT/OTHER PROFESSIONAL CARE

WHAT TYPES OF PROFESSIONAL CARE HAVE YOU RECEIVED OR ARE YOU CURRENTLY RECEIVING? (check all that apply and described):

Physicians Name: ____________________ Date: ____________________

Results and recommendations: ____________________

Physiatrist 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 Physicians Name: ______________________ Date: ________________
Results and recommendations: ____
Other / Name: ____
Results and recommendations: ____

Do you have a history of allergies? Yes O NO O
If yes, please explain: ____
Has a neurological evaluation been performed? Yes O NO O
If yes, by whom? ______________________ Date: ______________________
Results: ____
Has a psychological evaluation been performed? Yes O No O
If yes, by whom? ______________________ Date: ______________________
Results: ____
Has a speech and language evaluation been performed? Yes O No O
If yes, by whom? ______________________ Date: ______________________

VISUAL HISTORY

Have you had a previous vision evaluation? Yes O No O
If yes, doctor's name: ____
Date of last evaluation: ____
Reason for examination: ____
Were glasses, contact lenses or other optical devices recommended? Yes O No O
If yes, what? ____
Are they used? Yes O NO O If yes, when? ____________________________________
Were any additional tests, treatments, or therapies recommended concerning your vision?
Yes O No O If yes, what? ____
Did you undergo these treatments? Yes O NO O Explain: ____________________
Results and recommendations: ____

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING:

	Yes	No	Also present before Injury ?
Eye aches	O	O	O
Eyes pull or tug	O	O	O
Difficulty moving or turning eyes	O	O	O
Pain with movement of eyes	O	O	O
Eye redness	O	O	O
Burning eyes	O	O	O
Watery eyes	O	O	O
Itchy eyes	O	O	O
Brightness is bothersome	O	O	O
Motion sickness / car sickness	O	O	O
Headaches	O	O	O
Blurred vision	O	O	O
Difficulty changing focus far to near	O	O	O
Double vision	O	O	O
One eye turns in, out, up or down	O	O	O
Movement of objects in the environment is bothersome	O	O	O
Fluorescent light is bothersome	O	O	O
Patterned wallpaper or carpets are bothersome	O	O	O
Head moves when reading	O	O	O
Lose place often when reading	O	O	O
Words jump or move around when reading	O	O	O
Short attention span for reading or writing	O	O	O
Skip words frequently when reading	O	O	O
Discomfort when reading	O	O	O
Loss of interesting /concentration when doing close work	O	O	O
Orient writing/drawing poorly on page	O	O	O
Squinting, covering or closing one eye	O	O	O
Head tilts during desk work	O	O	O
Avoid reading or writing	O	O	O
Difficulty with dressing	O	O	O
Difficulty with bathing/personal hygiene	O	O	O
Difficulty following a series of directions	O	O	O
Difficulty using both sides of the body together	O	O	O
Dislike heights	O	O	O
Awkward, poor balance	O	O	O
Dizziness	O	O	O
Confusion / disorientation	O	O	O

	Yes	No	Also present before Injury ?
Get lost often	O	O	O
Bothered by noise	O	O	O
Bothered by touch	O	O	O
Difficulty remembering things heard	O	O	O
Difficulty remembering things seen	O	O	O
Difficulty remembering name of objects	O	O	O
Difficulty remembering people's names	O	O	O
Difficulty recalling information known in the past	O	O	O
Difficulty remembering formerly familiar people / object	O	O	O
Difficulty performing tasks formerly easy / routine	O	O	O
Difficulty with time management	O	O	O
Difficulty with numbers	O	O	O
Difficulty counting money	O	O	O

Why do you feel the need for a vision evaluation today? ______________________________

____

____

____

LIFESTYLE:

Do you feel your vision interferes with activities of daily living? Yes O NO O

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

____

____

____

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

____

____

What activities 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 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? ______________________________

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss / Gain	O	O	O
INTEGUMENTARY (Skin)	O	O	O
NEUROLOGICAL			
Headaches	O	O	O
Migraines	O	O	O
Seizures	O	O	O
EYES			
Loss of vision	O	O	O
Blurred Vision	O	O	O
Distorted Vision / Halos	O	O	O
Loss of Side Vision	O	O	O
Double Vision	O	O	O
Dryness	O	O	O
Mucous Discharge	O	O	O
Redness	O	O	O
Sandy or Gritty Feeling	O	O	O
Itching	O	O	O
Burning	O	O	O
Foreign Body Sensation	O	O	O
Excess Tearing/ Watering	O	O	O
Glare / Light Sensitivity	O	O	O
Eye Pain or Soreness	O	O	O
Chronic Infection of Eye or Lid	O	O	O
Sties or Chalazion	O	O	O

	NO	YES	?
EARS, NOSE, MOUTH THROAT			
Allergies / Hay Fever	O	O	O
Sinus Congestion	O	O	O
Runny Nose	O	O	O
Post-Nasal Drip	O	O	O
Chronic Bronchitis	O	O	O
Dry Throat / Mouth	O	O	O
RESPIRATIORY			
Asthma	O	O	O
Chronic Bronchitis	O	O	O
Emphysema	O	O	O
VASCULAR / CARDIOVASCULAR			
Diabetes	O	O	O
Heart Pain			
High Blood Pressure	O	O	O
Vascular Disease	O	O	O
GASTROINTESTINAL			
Diarrhea	O	O	O
Constipation	O	O	O
GENITOURINARY			
Genitals / Kidney / Bladder	O	O	O
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	O	O	O
Muscle Pain	O	O	O
Joint Pain	O	O	O

REVIEW OF SYSTEMS	NO	YES	?
Flashes / Floaters in Vision	O	O	O
Tired Eyes	O	O	O
ENDOCRINE			
Thyroid / Other Glands	O	O	O

	NO	YES	?
LYMPHATIC / HEMATOLOGIC			
Anemia	O	O	O
Bleeding Problem	O	O	O
ALLERGIC / IMMUNOLOGIC	O	O	O

PSYCHIATRIC	O	O	O

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

____

____

____

____

Family History

Please note any family history (parent, grandparent, siblings, children; living or deceased) for the following condition:

DISEASE / CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	O	O	O	____________
Cataract	O	O	O	____________
Crossed Eye	O	O	O	____________
Amblyopia	O	O	O	____________
Glaucoma	O	O	O	____________
Macular Degeneration	O	O	O	____________
Retinal Detachment / Disease	O	O	O	____________
Arthritis	O	O	O	____________
Cancer	O	O	O	____________
Diabetes	O	O	O	____________
Heart Disease	O	O	O	____________
High Blood Pressure	O	O	O	____________
Kidney Disease	O	O	O	____________
Lupus	O	O	O	____________
Thyroid Disease	O	O	O	____________
Other ____________	O	O	O	____________

SOCIAL HISTORY:

Do you use tobacco products? O NO O YES If yes, type / amount/ how long: ______________________

Do you drink alcohol? O NO O YES If yes, type / amount/ how long: ______________________

Do you use illegal drugs? O NO O YES If yes, type / amount/ how long: ____________________

REPORT POLICIES

Would you like copies of any reports? O Yes O No

Would you like copies of any reports sent to anyone else? If so, please list name and address. ____________________

____

Please sign below to give us permission to release information to the above sources. (Valid for 90 days only)

Signed ____________________ Date ____________________

I, ____________________understand that I/MY dependents are eligible for ____________________ Insurance through MY/SPOUSE'S Employment. I am aware that if the above is not true, I or the person financially responsible for me, are responsible for all charges related to services provide to me. I agree that if the above is not true, I or the person financially responsible will pay in full for all such charges.

____

Signature