learning · sport · rehab
VISION BEYOND 20/20

Full Name: _____ **Preferred Name:** _____

DOB: _____(MM/DD/YYYY) **Gender : M / F** **Marital Status:** *Single Married Divorced Separated Widowed Other*

Address: _____ **City:** _____ **State/Zip:** _____

Home Ph: ( )_____ **Wk Ph: ( )**_____ **Other/Cell ( )**_____

Email: _____

Emergency Contact: _____ _____ _____
(Name) *(Phone Number)* *(Relationship to Patient)*

Employer: _____ **Occupation:**_____

Business Address: _____ **Phone Number:**_____

Whom can we thank for referring you to our office? _____

Phone: _____ **Address:**_____

VISUAL HISTORY

For what reason(s) are you visiting our office today?

_____

Has your vision been previously evaluated? Yes ☐ No ☐

Date of last Vision Exam: _____ Doctor: _____ Date of last dilation: _____

Do you wear glasses, contact lenses, or other optical devices prescribed? **Y N** If YES, which? _____

Do you use them? Yes ☐ No ☐ If yes, how often? _____ If no, why not? _____

If you wear contact lenses, how long have you worn them? _____

What type of lenses do you have (ie. hard, soft, gas-permeable)? _____

What solutions do you use?

_____

PRESENT CONDITION(S)

Does the patient currently suffer from (please check all that apply):

- ❑ Blurred vision at distance or near
- ❑ Red, burning, itchy or watery eyes
- ❑ Headaches
- ❑ Loss of place or skips lines when reading
- ❑ Motion / car sickness
- ❑ Double vision at distance or near
- ❑ Difficulty sustaining reading / writing
- ❑ Repeats or omits words when reading

List any other complaints your child makes concerning his/her vision:

_____

_____

MEDICAL HISTORY

Physician's Name: _____ Date of most recent visit: _____

Reason for visit: _____

Current Medications (including vitamins and supplements):

_____

_____

Is patient allergic to any medications? _____

REVIEW OF SYSTEMS (*Please mark the appropriate response(s) below)*

Constitutional *None*_____
- ❑ headaches
- ❑ weight loss
- ❑ fever
- ❑ fatigue
- ❑ trauma
- ❑ migraines
- ❑ cancer _____

Skin/Integumentary *None*_____
- ❑ eczema/psoriasis
- ❑ skin cancer
- ❑ acne

Cardiovascular *None*_____
- ❑ heart disease
- ❑ high blood pressure
- ❑ stroke
- ❑ high cholesterol

Respiratory *None*_____
- ❑ asthma
- ❑ bronchitis
- ❑ emphysema

Neurological *None*_____
- ❑ multiple sclerosis
- ❑ epilepsy

Gastrointestinal *None*_____
- ❑ ulcer
- ❑ food allergy
- ❑ digestive disorder

Genitourinary *None*_____
- ❑ urinary tract infections
- ❑ STD

Musculoskeletal *None*_____
- ❑ fibromyalgia
- ❑ arthritis
- ❑ muscular dystrophy

Ears, Nose, Throat *None*_____
- ❑ hearing problems
- ❑ upper respiratory tract infection

Psychiatric *None*_____
- ❑ depression
- ❑ panic disorder
- ❑ ADD / ADHD

Endocrine *None*_____
- ❑ diabetes
- ❑ thyroid problems
- ❑ hormonal problems

Hematologic/Lymphatic *None*_____
- ❑ anemia
- ❑ leukemia
- ❑ clotting disorder

Allergic/Immunologic *None*_____
- ❑ seasonal allergies
- ❑ lupus

Eyes *None*_____
- ❑ amblyopia / lazy eye
- ❑ strabismus/ crossed eye
- ❑ glaucoma
- ❑ eye surgery _____
- ❑ cataract

FAMILY HISTORY

Is there any history of the following? *(please check all that apply)*

YES	*Relationship to Patient?*	YES	*Relationship to Patient?*
❑ Diabetes	_____	❑ Amblyopia	_____
❑ High Blood Pressure	_____	❑ Strabismus	_____
❑ Epilepsy or Seizures	_____	❑ Glaucoma	_____
❑ Thyroid	_____	❑ Macular Degeneration	_____

If other, please explain:

_____

Immunization Information

Immunization type: _____ Date: _____

Immunization type: _____ Date: _____

Immunization type: _____ Date: _____

Immunization type: _____ Date: _____

Any reactions to immunization(s)? Yes ☐ No ☐ If yes,, please explain: _____

_____

List illnesses, bad falls, high fevers, other accidents such as auto, bicycle, etc.

Age	Severe	Mild	Complications

Are you generally healthy? Yes ☐ No ☐

If no, explain: _____

Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes ☐ No ☐

If yes, please list: _____

Has a neurological evaluation been performed? Yes ☐ No ☐

By whom? _____ Results and recommendations: _____

Has a psychological evaluation been performed? Yes ☐ No ☐

By whom? _____ Results and recommendations: _____

Has an occupational therapy evaluation been performed? Yes ☐ No ☐

By whom? _____ Results and recommendations: _____

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

	Patient	Family	Relationship to Patient
Chromosomal Imbalance	☐	☐	_____
Learning Disability	☐	☐	_____
Epilepsy or Seizures	☐	☐	_____
Multiple Sclerosis	☐	☐	_____
"Crossed" or "Wall" eye	☐	☐	_____

If other, please explain: _____

_____

NUTRITIONAL INFORMATION

How would you classify your current Diet: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Does you like or crave sweets? Yes ☐ No ☐

If yes, what types? _____

Are you physically active? Yes ☐ No ☐ Please rate your level of activity: Mildly ☐ Moderately ☐ Extremely ☐

Are there periods of:

Very high energy? Yes ☐ No ☐

Very low energy? Yes ☐ No ☐

Please explain: _____

HAVE YOU OR ANYONE ELSE EVER NOTICED THE FOLLOWING:

Please check all that apply. Some may not apply because of your current health condition and/or lifestyle.

	Yes	No	If yes, how often?
Eyes frequently reddened	☐	☐	_____
Frequent eye rubbing	☐	☐	_____
Frequent sties	☐	☐	_____
Frowning	☐	☐	_____
Bothered by light	☐	☐	_____
Frequent blinking	☐	☐	_____
Closing or covering one eye	☐	☐	_____
Difficulty seeing distant objects	☐	☐	_____
Head close to paper when reading or writing	☐	☐	_____
Avoids reading	☐	☐	_____
Prefers being read to	☐	☐	_____
Tilts head when reading	☐	☐	_____
Tilts head when writing	☐	☐	_____
Moves head when reading	☐	☐	_____
Confuses letter or words	☐	☐	_____
Reverses letter or words	☐	☐	_____
Confuses right and left	☐	☐	_____
Skips, rereads or omits words	☐	☐	_____
Loses place while reading	☐	☐	_____
Vocalizes when reading silently	☐	☐	_____
Reads slowly	☐	☐	_____
Uses finger as a marker	☐	☐	_____
Poor reading comprehension	☐	☐	_____
Comprehension decreases over time	☐	☐	_____
Writes or prints poorly	☐	☐	_____
Writes neatly but slowly	☐	☐	_____
Does not support paper when writing	☐	☐	_____
Awkward or immature pencil grip	☐	☐	_____
Frequent erasures	☐	☐	_____
Tires easily	☐	☐	_____
Difficulty copying from chalkboard	☐	☐	_____

Difficulty recognizing same word on diff page	☐	☐	_____
Poor word attack skills	☐	☐	_____
Difficulty with memory	☐	☐	_____
Remembers better what hears than sees	☐	☐	_____
Responds better orally than by writing	☐	☐	_____
Seems to know material, does poorly on tests	☐	☐	_____
	Yes	No	If yes, how often?
Dislikes / avoids near tasks	☐	☐	_____
Short attention span / loses interest	☐	☐	_____
Poor large motor coordination	☐	☐	_____
Poor fine motor coordination	☐	☐	_____
Difficulty with scissors / small hand tools	☐	☐	_____
Dislikes / avoids sports	☐	☐	_____
Difficulty catching or hitting a ball	☐	☐	_____

COMPUTERS:

Do you use a computer in your work, school, or leisure time activities? Yes ☐ No ☐

If so, indicate the types of computer work you perform:

- ☐ Word processing
- ☐ Programming
- ☐ Data entry
- ☐ Internet
- ☐ Games / Leisure activities
- ☐ Other (explain): _____

How many hours do you spent in front of a computer screen each day? _____

How do your eyes feel after working at the computer? _____

What is the approximate distance from:

Your eyes to the screen? _____
Your eyes to the keyboard? _____
Your eyes to your source documents? _____

Where is the top of the screen located?

- ☐ Above your straight-ahead eye level
- ☐ At eye level
- ☐ Below eye level

Where is the computer screen located when you are seated?

- ☐ Directly in front of you
- ☐ To your right
- ☐ To your left

Where are your source documents located?

- ☐ Directly in front of you when seated
- ☐ To your right
- ☐ To your left
- ☐ Flat (horizontal) or vertical

Do you experience any of the following lighting problems in your work area?

☐Glare from windows or other light sources
☐ Reflections on your computer screen
☐ Difficulty reading source documents

Do you wear glasses, contact lenses, or other optical devices for computer work?
☐ Glasses
☐ Contact lenses
☐ Other (explain): _____
Please describe any problems you have with your vision, current glasses or contact lenses for computer work: _____

_____

_____

EMPLOYMENT/SCHOOL:

Current position: _____AND/OR Major course of study: _____
How many hours daily do you spend at a desk? _____
How many hours daily do you spend reading or studying?_____
How many hours daily do you spend working at near distances? _____
Do you feel you are achieving to your potential in work or school? Yes ☐ No ☐
Do you feel you are getting adequate return for the amount of effort you put into a task? Yes ☐ No ☐
If no, please explain: _____

_____
Does your work or course of study demand comprehension from the written word? Yes ☐ No ☐
Describe briefly your daily activities at work or in school: _____

_____

HOBBIES/SPORTS:

Describe the types of activities that comprise the majority of your leisure time:_____

_____

_____

Do you watch TV? Yes ☐ No ☐
If yes, how many hours per day? _____
How many days per week? _____
Are you seriously involved with athletics? Yes ☐ No ☐
Do you feel you are achieving up to your potential in sports/athletics? Yes ☐ No ☐
Of all the sports you have played:
List the ones in which you excel: _____
List the ones in which you do poorly/avoid:_____

IS THERE ANY OTHER INFORMATION YOU FEEL WOULD BE HELPFUL/IMPORTANT IN YOUR TREATMENT?

_____

_____

IMPORTANT INFORMATION REGARDING HIPAA PRIVACY:

_____ *(initials)* I acknowledge that I have read a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information, in part, can and will be used to:

- *Conduct, plan and direct my treatment and follow-up among the health-care providers who may be involved in that treatment directly and indirectly*
- *Obtain payment from third-party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician certifications.*

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 Vision NOW 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 or the treatment of my child or ward.

Signature of Patient or Authorized Representative_____ **Date**_____

Please note that we request a minimum of 24 hours notice if you are unable to keep your appointment.

(For office use only:)

Reviewed by _____ Date_____ || Reviewed by _____ Date_____ Changes_____ || Reviewed by _____ Date_____ Changes_____