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ADULT'S VISION QUESTIONNAIRE

PATIENT INFORMATION

Patient Name: ____________________________________ Date of Birth: ___________ Age:______

Gender: ☐Male ☐Female Email Address: _______________________________

Home Phone: ______________________________ Cell Phone: ______________________________

Would you like to receive text message reminders? Yes☐ No☐

____ ______________________, __________ __________

Street Address (above line) 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: ___________