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*Please bring this form to your (or your child's) appointment. This assists us in determining the visual performance tests needed. If your child has an Individual Education Plan (IEP), or other testing which we should be aware of, please provide a copy.*

## Neuro History (Adult)

Date \_\_\_\_\_ Completed By \_\_\_\_\_  
How did you learn about A B See? \_\_\_\_\_

### General Information

Patient's name \_\_\_\_\_  
(LAST) (FIRST) (M)

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Gender F M  
Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_

Fax number ( ) \_\_\_\_\_

What is or was your occupation? \_\_\_\_\_

Employer \_\_\_\_\_

Work Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_

May we contact you at your business? Yes  No

If married, name of spouse \_\_\_\_\_

(Last) (First) (M)

Cell Phone ( ) \_\_\_\_\_

E-mail \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_

Patient's Insurance Information

Primary Health Care Plan \_\_\_\_\_

Medical Billing Address \_\_\_\_\_

Policy Holder \_\_\_\_\_

Policy Number \_\_\_\_\_ Group # \_\_\_\_\_

Emergency contact \_\_\_\_\_

Caregiver \_\_\_\_\_

Please check any of the following professionals that you have seen related to your injury:

- |   |   |
|---|---|
| <input type="checkbox"/> Psychiatrist                 | <input type="checkbox"/> Family Physician       |
| <input type="checkbox"/> Neurologist                  | <input type="checkbox"/> Speech Therapist       |
| <input type="checkbox"/> Psychologist                 | <input type="checkbox"/> Physical Therapist     |
| <input type="checkbox"/> Psychiatrist                 | <input type="checkbox"/> Neuropsychologist      |
| <input type="checkbox"/> Massage Therapist            | <input type="checkbox"/> Emergency Room Doctor  |
| <input type="checkbox"/> Ophthalmologist              | <input type="checkbox"/> Occupational Therapist |
| <input type="checkbox"/> Audiologist/Otolaryngologist | <input type="checkbox"/> Osteopath              |
| <input type="checkbox"/> Chiropractor                 |   |
| <input type="checkbox"/> Other _____                  |   |

### Initial Treatment

First treatment date: \_\_\_\_\_

Name of Doctor: \_\_\_\_\_

Where were you seen?

Office \_\_\_\_\_

Hospitalized  Yes  No

How Long? \_\_\_\_\_

Initial treatment consisted of: \_\_\_\_\_

What prognosis/recommendations were you given?

**Subsequent/Current Professional Care**

What types of professional care have you received or are you currently receiving?  
(Check all that apply and describe)

Physician Name:

\_\_\_\_\_  
Location: \_\_\_\_\_  
Results/Recommendations: \_\_\_\_\_  
\_\_\_\_\_

Neurologist Name:

\_\_\_\_\_  
Location: \_\_\_\_\_  
Results/Recommendations: \_\_\_\_\_  
\_\_\_\_\_

Physical Therapist Name:

\_\_\_\_\_  
Location: \_\_\_\_\_  
Results/Recommendations: \_\_\_\_\_  
\_\_\_\_\_

Speech/Language Therapist Name:

\_\_\_\_\_  
Location: \_\_\_\_\_  
Results/Recommendations: \_\_\_\_\_  
\_\_\_\_\_

Psychologist/Psychiatrist Name:

\_\_\_\_\_  
Location: \_\_\_\_\_  
Results/Recommendations: \_\_\_\_\_  
\_\_\_\_\_

Optometrist/Ophthalmologist Name:

\_\_\_\_\_  
Location: \_\_\_\_\_  
Results/Recommendations: \_\_\_\_\_  
\_\_\_\_\_

Other/Name:

\_\_\_\_\_  
Location: \_\_\_\_\_  
Results/Recommendations: \_\_\_\_\_  
\_\_\_\_\_

Was the head Trauma:

Accident/Injury Yes  No

Date: \_\_\_\_\_  
Type: Motor vehicle \_\_\_\_\_  
Fall \_\_\_\_\_  
Blow to Head \_\_\_\_\_  
Industrial \_\_\_\_\_  
Other \_\_\_\_\_

Medical/Surgical?  Yes  No

Date: \_\_\_\_\_  
Type: Medication-related \_\_\_\_\_  
Stroke \_\_\_\_\_  
Aneurysm \_\_\_\_\_  
Hemorrhage \_\_\_\_\_  
Drug Abuse \_\_\_\_\_  
Poison/Toxic Substance \_\_\_\_\_  
Other \_\_\_\_\_

Was injury:

Open Head (bleeding)  Yes  No  
Closed Head (non-bleeding)  Yes  No

What part of your head was affected?

(check all that apply)

- |                                      |                                       |
|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Forehead    | <input type="checkbox"/> Right side   |
| <input type="checkbox"/> Left side   | <input type="checkbox"/> Back of Head |
| <input type="checkbox"/> Top of Head | <input type="checkbox"/> Face         |
| <input type="checkbox"/> Brainstem   |                                       |

Did you lose consciousness?  Yes  No

If yes, how long? \_\_\_\_\_

Were you in a coma?  Yes  No

If yes, how long? \_\_\_\_\_

**Medical History**

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Please check any of the following which pertains: Last Medical Examination Date \_\_\_\_\_

**Allergies/ Immunology**

- Drug Allergies
- Environmental Allergy
- Rheumatoid Arthritis
- Lupus
- Other

List all allergies: \_\_\_\_\_

**Respiratory**

- Allergies
- Cigarette Smoker
- Asthma
- Bronchitis
- Other

Explain: \_\_\_\_\_

**Psychiatric**

- Depression
- Panic Disorder
- Schizophrenia
- Memory Loss
- Other

Explain: \_\_\_\_\_

**Integumentary**

- Eczema
- Rosaces
- Psoriasis
- Ring Worm
- Other

Explain: \_\_\_\_\_

**Cardiovascular**

- Heart Disease
- Hypertension
- Stroke
- Vascular Disease
- Other

Explain: \_\_\_\_\_

**Musculoskeletal**

- Fibromyalgia
- Muscular Dystrophy
- Osteoarthritis
- Cold Extremities
- Other

Explain: \_\_\_\_\_

**Constitutional**

- General Good Health
- Recent Weight Change
- Fever
- Fatigue
- Developmental Disability
- Other

Explain: \_\_\_\_\_

**Neurological**

- Paralysis
- Numbness or Tingling
- Headaches
- Light Headed or Dizzy
- Convulsions/ Seizures
- Tremors
- Head Injuries
- Other

Explain: \_\_\_\_\_

**Eye/Ear/Nose**

- Tubes in Ears
- Earaches or Drainage
- Chronic Sinus Problems
- Glaucoma
- Cataracts
- Eye Turn
- Hearing Loss Injury
- Other

Explain: \_\_\_\_\_

**Hematological/ Lymphatic**

- Anemia
- Bleeder
- Slow to heal after cut
- Leukemia
- Large volume blood loss
- Enlarged glands
- Blood transfusions
- Other

Explain: \_\_\_\_\_

**Gastrointestinal**

- Loss of appetite
- Bowel movement changes
- Abdominal pain
- Crohn's
- Colitis
- Ulcers
- Other

Explain: \_\_\_\_\_

**Endocrine**

- Non insulin dep. Diabetic
- Insulin dep. Diabetic
- Thyroid dysfunction
- Hormonal dysfunction
- Other

Explain: \_\_\_\_\_

*This information is confidential. However, you may discuss this portion directly with the doctor if you prefer.*

Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you drive?  Yes  No If yes, do you have visual difficulty when driving?  Yes  No

If yes, please describe: \_\_\_\_\_

Do you use tobacco products?  Yes  No If yes, type/amount/how long? \_\_\_\_\_

Do you drink alcohol?  Yes  No If yes, type/amount/how long? \_\_\_\_\_

Do you use illegal drugs?  Yes  No If yes, type/amount/how long? \_\_\_\_\_

Have you ever been exposed to or infected with:  Gonorrhea  Hepatitis  HIV  Syphilis

**Visual History**

Previous eye examination:

Date: \_\_\_\_\_

Doctor's name: \_\_\_\_\_

Location: \_\_\_\_\_

Reason for examination: \_\_\_\_\_

\_\_\_\_\_

Were glasses prescribed?  Yes  No

How are they worn? \_\_\_\_\_

Are contact lenses worn?  Yes  No

How are they worn? \_\_\_\_\_

When was the visual difficulty first noted? \_\_\_\_\_

\_\_\_\_\_

Did the problem occur suddenly, related to accident or trauma? Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have there been any treatments to remedy the problem such as:

Vision therapy \_\_\_\_\_

Patching \_\_\_\_\_

Eye surgery \_\_\_\_\_

Other \_\_\_\_\_

\_\_\_\_\_

Have you seen improvements with therapy? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other related information regarding vision:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Motor Vehicle Accident**

Type of vehicle you were in: \_\_\_\_\_

Other vehicle(s) involved: \_\_\_\_\_

Were you sitting in:

Front Seat  Back Seat  Middle

Left Side  Right Side  Unusual Position

Which restraints were used? (Check all that apply)

Lap  Shoulder  Car Seat

Booster Seat  Air Bag

Speed of vehicle you were in: \_\_\_\_\_

Speed of other vehicle or object: \_\_\_\_\_

Did your vehicle hit another object?  Yes  No

Or did the other vehicle hit your vehicle?  Yes  No

If yes, where was your vehicle hit:

Head on  Toward front  Drivers side

Rear ended  Toward rear  Passenger side

Did you experience whiplash?  Yes  No

Did you hit your head?  Yes  No

If yes, on what? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Lifestyle**

Do you feel your vision interferes with activities of daily living?

Yes  No

Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What changes/limitations in your daily life do you attribute to your injury/surgery?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Symptoms Immediately Following Head Trauma

Please check all that apply:

- |   |  |
|---|--|
| <input type="checkbox"/> Double vision              | <input type="checkbox"/> Headache        |
| <input type="checkbox"/> Blurred vision             | <input type="checkbox"/> Dizziness       |
| <input type="checkbox"/> Pain around eyes           | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Flashes of light           | <input type="checkbox"/> Disorientation  |
| <input type="checkbox"/> Floaters                   | <input type="checkbox"/> Vomiting        |
| <input type="checkbox"/> Blindness                  | <input type="checkbox"/> Neck pain       |
| <input type="checkbox"/> Turned eyes                | <input type="checkbox"/> Whiplash        |
| <input type="checkbox"/> Restricted field of vision | <input type="checkbox"/> Loss of memory  |

### Symptoms: Current

Yes No

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Eyes ache  |
| <input type="checkbox"/> | <input type="checkbox"/> | Eyes pull or tug                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty moving or turning eyes                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain with movement of eyes                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Eyes twitch  |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in or around eyes                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye redness  |
| <input type="checkbox"/> | <input type="checkbox"/> | Burning eyes   |
| <input type="checkbox"/> | <input type="checkbox"/> | Watery eyes  |
| <input type="checkbox"/> | <input type="checkbox"/> | Itchy eyes   |
| <input type="checkbox"/> | <input type="checkbox"/> | Brightness is bothersome                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in stores or malls                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Motion sickness/car sickness                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches  |
| <input type="checkbox"/> | <input type="checkbox"/> | Blurred vision                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty changing focus far to near                |
| <input type="checkbox"/> | <input type="checkbox"/> | Double vision  |
| <input type="checkbox"/> | <input type="checkbox"/> | One eye turns in, out, up or down                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Movement of objects in the environment is bothersome |
| <input type="checkbox"/> | <input type="checkbox"/> | Fluorescent light is bothersome                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Patterned wallpaper or carpets is bothersome         |
| <input type="checkbox"/> | <input type="checkbox"/> | Head moves when reading                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Lose place often when reading                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Words jump or move around when reading               |
| <input type="checkbox"/> | <input type="checkbox"/> | Short attention span for reading or writing          |

Yes No

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Skip words frequently when reading                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Discomfort when reading                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of interest/concentration when doing close work    |
| <input type="checkbox"/> | <input type="checkbox"/> | Orient writing/drawing poorly on page                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Squinting, covering or closing one eye                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Head tilts during desk work                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Holds books too close                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Avoids reading or writing                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty with peripheral vision                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Objects jump in and out of field of view                |
| <input type="checkbox"/> | <input type="checkbox"/> | Reduced depth perception                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Tunnel vision/loss of visual field                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Flashes of light  |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty with dressing                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty with bathing/personal hygiene                |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty following a series of directions             |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty using both sides of the body together        |
| <input type="checkbox"/> | <input type="checkbox"/> | Dislike heights   |
| <input type="checkbox"/> | <input type="checkbox"/> | Awkward, poor balance                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness   |
| <input type="checkbox"/> | <input type="checkbox"/> | Confusion/disorientation                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Get lost often  |
| <input type="checkbox"/> | <input type="checkbox"/> | Bothered by noises                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Bothered by touch                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty remembering things heard                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty remembering things seen                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty remembering name of objects                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty remembering people's names                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty recalling past information known in the past |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty remembering formerly familiar people/objects |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty performing tasks formerly easy/routine       |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty with time management                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty with numbers                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty counting money                               |

What do you hope a Visual Rehabilitation Program will do for you? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation and to better meet your specific visual needs.

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

### COVID-Quality of Life Questionnaire

Check the column which best represents the occurrence of each symptom.

Completed by: \_\_\_\_\_

	Never	Seldom	Occasional	Frequently	Always
Headaches with near work					
Words run together when reading					
Burning, itchy, watery eyes					
Skips/repeats lines when reading					
Head tilt/closes one eye when reading					
Difficulty copying from the chalkboard					
Avoids near work/reading					
Omits small words when reading					
Writes up/down hill					
Misaligns digits/columns of numbers					
Difficulty comprehending what is read					
Holds document/book too close					
Trouble keeping attention on reading					
Difficulty completing assignments					
Always says "I can't" before trying					
Clumsy, knocks things over					
Does not use his/her time well					
Loses belongings/things					
Forgetful/poor memory					

Other comments: