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Please bring this form to your appointment. This assists us in determining the visual performance tests needed.

Adult History

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 _____

Visual History

Previous eye examination:

Date: _____

Doctor's name: _____

Location: _____

Reason for examination: _____

Do you wear glasses?

- Yes No
 Constantly Occasionally
 Near Far

If you have more than one pair of glasses, please describe how/when you use them: _____

Do you wear contact lenses?

- Yes No
 Full time wear Occasional wear

Please describe your visually demanding activities and any difficulties you encounter in doing them.

Visual demands (reading, computer, etc.):

At work: _____

At play (sports, hobbies): _____

Any history of the following? (please check)

- | | | |
|--------------------------|--------------------------|---------------------|
| You | Family | |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye turn/Strabismus |
| <input type="checkbox"/> | <input type="checkbox"/> | Lazy Eye/Amblyopia |
| <input type="checkbox"/> | <input type="checkbox"/> | Retinal disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Color deficiency |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | Cataracts |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye Surgery |

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

Medical History Continued

Most recent medical examination:
 Date: _____
 Doctor's name: _____
 Location: _____
 Results: _____

Medications:

Conditions:

List illnesses, bad falls, head injuries, high fever, surgeries, etc. _____

Complications and ages: _____

Are you generally healthy? _____
 Are there any chronic problems like asthma, hay fever, allergies? _____
 If so, please list: _____

Has a neurological evaluation been performed? _____
 By whom? _____
 Results: _____

Has a psychological evaluation been performed? _____
 By whom? _____
 Results: _____

Have you ever received:
 Occupational therapy services? _____
 By whom and when? _____
 Results: _____

Physical therapy services? _____
 By whom? _____
 Results: _____

Speech therapy services? _____
 By whom? _____
 Results: _____

Other therapy? _____

Present Situation

Is there any evidence that some visual malfunction may be present? _____

 If so, what? _____

Is your visual malfunction interfering with your ability to perform your daily functions either at home or work?

Have there been any treatments to remedy the problem such as:
 Vision therapy _____
 Patching _____
 Eye surgery _____
 Other _____

Have you seen improvements with therapy? _____

Do you experience any of the following:

Headaches: Yes No
 When? _____

Blurred vision: Yes No
 When? _____

Double Vision: Yes No
 When? _____

Eyes "hurt or tired": Yes No
 When? _____

Difficulty reading: Yes No
 Describe? _____

Difficulty driving: Yes No
 When? _____

Difficulty coordinating eyes as a team: Yes No
 When? _____

Poor Depth perception/spatial judgments: Yes No
 Describe: _____

Other Visual perception problem: Yes No
 Describe: _____
 Eyes frequently reddened: Yes No
 If so, when? _____
 Frequent eye rubbing: Yes No
 If so, when? _____
 Frequent blinking: Yes No
 If so, when? _____
 Closing or covering one eye: Yes No
 If so, when? _____

Educational/Occupational History

Level of education received: _____

Please check all that apply to you:

- Yes No Slow learner
- Yes No Motion sensitive
- Yes No Poor diet/nutrition
- Yes No Difficult childhood
- Yes No History of substance abuse
- Yes No Light sensitive
- Yes No Touch sensitive
- Yes No Enjoy sports
- Yes No Read for enjoyment
- Yes No Hands on learner

- Yes No Head close to paper when reading or writing
- Yes No Tilting head when reading
- Yes No Tilting head when writing
- Yes No Confuses letters or words
- Yes No Reverses letters or words
- Yes No Skips, re-reads or omits words
- Yes No Vocalizes when reading silently
- Yes No Reads Slowly
- Yes No Uses finger as a marker
- Yes No Poor reading comprehension
- Yes No Writes or prints poorly
- Yes No Tires easily
- Yes No Avoids near tasks
- Yes No Short attention span
- Yes No Poor motor coordination
- Yes No Difficulty catching/ hitting a ball

Goals:

Satisfied with current occupational situation? Yes No

If no, please give a reason why. _____

Satisfied with level of education received? Yes No

If no, please give a reason why. _____

What do you hope a Visual Rehabilitation Program will do for you? _____

List any other complaints that you have concerning your vision: _____

Release of Information and Insurance Filing

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 A B See Vision Therapy Centers, SC. 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.

 Signature of patient or authorized representative

Date: _____

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: