Functional Vision Evaluation - Adult

Patient's Name: ___________________________Preferred Name: __________________
Date of Birth: ____________Age: __________Gender: M F
Home Address: _______________________ City: ___________________Zip: ___________
Phone Number: Home ( )____________ Cell: ( )____________ Work: ( )____________
Occupation: ____________________Employeer: _________________________________
E-mail: _______________________________________

Who may we thank for referring you? ___________________Profession: _____________
Address: _____________________________Phone: _______________________________

VISION HISTORY

Last Eye Examination Date: ____________Name of Doctor: _______________________
Recommendations advised at that time: ____
Please check all that apply:

- ▢ I wear glasses full-time
- ▢ I wear glasses only for reading
- ▢ I wear glasses for distance and remove them for reading
- ▢ I do not use glasses currently for anything
- ▢ I wear contact lenses
- ▢ I use prescription eye drops; list name and frequency: ____________________
  ____
- ▢ I use over-the-counter eye drops; name and frequency: ___________________
  ____

Have you ever been told you had a visual problem in the past? ▢ No ▢ Yes, If yes, please describe: ____
Please describe any activities you may encounter visual difficulties with (ie: reading, computer, etc.):
At work: ____
____
At play (sports, hobbies): ____
____

Do you experience any of the following symptoms?	No	Yes
Blurred distance vision	▢	▢
Blurred near vision	▢	▢
Eyestrain or visual fatigue	▢	▢

Headaches	▢	▢
Sensitivity to sunlight or bright lights	▢	▢
Double vision at distance	▢	▢
Double vision when reading	▢	▢
Words split or move on the page	▢	▢
Eyes hurt	▢	▢
Eyes feel like they are pulling	▢	▢
Car sickness/motion sickness	▢	▢
Cover or close one eye with near tasks	▢	▢
Loses place along lines when reading	▢	▢
Moves head when reading	▢	▢
Eye appears to turn inward/outward	▢	▢
Reads very slowly	▢	▢
Frequently blinks or rubs eyes with near work	▢	▢
Difficulty sustaining attention while reading	▢	▢
Difficulty understanding reading material	▢	▢
Avoids reading, used to read a lot more	▢	▢
Cannot use a computer	▢	▢
Poor depth judgement with daily tasks	▢	▢
Poorly organized handwriting	▢	▢
Clumsy, bumps into things often	▢	▢
Poor eye-hand coordination	▢	▢
Difficulty remembering where I put thing	▢	▢
Overwhelmed visually when in stores	▢	▢
Difficulty seeing in my peripheral vision	▢	▢
Difficulty seeing on my right or left side	▢	▢
Difficulty shifting my focus from near to far	▢	▢
Perceived movement of stationary objects	▢	▢
Unstable balance	▢	▢
Staring behaviors	▢	▢
Dry or irritated eyes	▢	▢
Fluorescent lights are very bothersome	▢	▢
Patterned wallpaper or carpet if difficult to look at	▢	▢

Have you ever had:	No	Yes	When/with whom?
Eye Surgery	▢	▢	________________________
Eye Patching	▢	▢	________________________
Eye Injury	▢	▢	________________________
Vision Therapy	▢	▢	________________________

MEDICAL HEALTH HISTORY

Please list all current medical conditions (ie: diabetes, high blood pressure, etc.):

____

____

____

Have you ever had a head injury/concussion? ▢ No ▢ Yes

If yes, please describe: ____

Do you have/use any of the following?

	No	Yes	Please describe
Vitamins/supplements	▢	▢	________________
Allergies to medications	▢	▢	________________
Allergies food	▢	▢	________________
Seasonal allergies	▢	▢	________________
Anxiety/depression/fears	▢	▢	________________

Medications: (please list all below)

________________ ________________ ________________

________________ ________________ ________________

________________ ________________ ________________

Physician's Name: ___________________________Date of Last Visit: __________

Office Location/Hospital: _______________________Phone: ___________________

Have you ever been evaluated by the following professionals?

Neurologist ▢ Yes ▢ No

Name: ___________________________Date of Last Visit: _______________

Office Location: ______________________Phone: _____________________

Results/recommendations given: ____________________________________

Psychologist ▢ Yes ▢ No

Name: ___________________________Date of Last Visit: _______________

Office Location: ______________________Phone: _____________________

Results/recommendations given: ____________________________________

Occupational Therapist ▢ Yes ▢ No

Name: ___________________________Date of Last Visit: _______________

Office Location: ______________________Phone: _____________________

Speech Therapist ▢ Yes ▢ No

Name: ___________________________Date of Last Visit: _______________

Office Location: ______________________Phone: _____________________

Audiologist ▢ Yes ▢ No
Name: ______________________ Date of Last Visit: ____________
Office Location: __________________ Phone: _________________
Other: _________________________ ▢ Yes ▢ No
Name: ______________________ Date of Last Visit: ____________
Office Location: __________________ Phone: _________________

Do you or a family member have any of the following?

	Myself	Family	Whom?
Diabetes	▢	▢	___________________
High Blood Pressure	▢	▢	___________________
Thyroid Disease	▢	▢	___________________
Multiple Sclerosis	▢	▢	___________________
Genetic Abnormalities	▢	▢	___________________
Epilepsy or Seizures	▢	▢	___________________
Cancer	▢	▢	___________________
Glaucoma	▢	▢	___________________
Macular Degeneration	▢	▢	___________________
Cataracts	▢	▢	___________________
Amblyopia (lazy eye)	▢	▢	___________________
Crossed or wall eye	▢	▢	___________________
Dyslexia	▢	▢	___________________
Learning Disability	▢	▢	___________________

What services are you **currently** receiving? Please check all that apply:

Occupational Therapy: ▢ No ▢ Yes No. times per week: _____
Physical Therapy: ▢ No ▢ Yes No. times per week: _____
Speech Therapy: ▢ No ▢ Yes No. times per week: _____
Cognitive Therapy: ▢ No ▢ Yes No. times per week: _____
Counseling: ▢ No ▢ Yes No. times per week: _____
Other: Please describe: ______________________________________

LIFESTYLE / SOCIAL HISTORY

Are you currently working? ▢ No ▢ Yes How often? __________
Are you currently a student? ▢ No ▢ Yes Where? ____________
Do you smoke? ▢ No ▢ Yes How often? __________
Do you exercise? ▢ No ▢ Yes How often? __________

EDUCATION/OCCUPATIONAL HISTORY

Level of education received: ______________________________

Please check all that apply to you:

Slow learner	▢ Yes	▢ No
Hands on learner	▢ Yes	▢ No
Auditory learner	▢ Yes	▢ No
Reads for enjoyment	▢ Yes	▢ No

Is there anything else you would like to comment on regarding your current vision or general health?

____
____
____

FINANCIAL POLICY

We require payment at the time of the visit. We will provide you with a detailed receipt at the completion of each session for insurance reimbursement submission.

Please sign that you understand the above:

Signed: ____ Date: _______________________