Patient Name: _____Date Form Completed: _____

PATIENT HISTORY QUESTIONNAIRE – ADULT (18+ YEARS OLD)

As you complete this questionnaire, you will recognize the thoroughness and breadth of your scheduled vision evaluation. The few minutes spent in answering all questions will allow Dr. Kadet to better plan the flow of examination procedures and consider appropriate treatment options.

Thank you for the time and effort expended in completing our questionnaire. Leave blank or put "N/A" beside any questions not applicable to you. If you don't know the answer to a question_____

_____

, it is OK to say so.

PRESENT SITUATION, SYMPTOMS AND/OR CONDITIONS

What are the concerns prompting this vision evaluation?

_____

_____

Is this appointment due to an accident? No □ Yes □

If yes, what type of an accident? _____

When did this accident occur? _____

Where did it occur? _____

Have you been diagnosed to have Traumatic Brain Injury? No □ Yes □

If yes, is an attorney representing you? No □ Yes □

If yes, attorney's name: _____
Attorney's phone number: _____

In your opinion, may vision be impacting work performance?_____

How long have these concerns been observed?_____

Last Vision evaluation (year):_____ Doctor:_____ City:_____ State:___

Do you currently wear glasses?_____ Reason?_____ Year first prescribed:_____

Have you previously worn glasses, but not at present?_____ Reason for discontinued wear?_____

_____

Do you currently wear contact lenses?_____

Have you previously received vision therapy?_____ Reason:_____ Doctor:_____

Have you had eye surgery?_____ Reason:_____ Doctor:_____

Patient Name: _____Date Form Completed: _____

Other family members receiving vision care services:

Name	Age	Visual Situation
_____		
_____		

Doctor Information

Check the box if you have, or you have observed, the following:

- ☐ Blurred vision at far
- ☐ Double vision
- ☐ Headaches
- ☐ Motion sickness/Car sickness
- ☐ Eyes frequently reddened
- ☐ Light sensitivity
- ☐ Head close to paper when reading or writing
- ☐ Avoids (dislikes) reading or near tasks
- ☐ Tilts head when reading
- ☐ Moves head when reading
- ☐ Skips, inserts, or rereads words
- ☐ Vocalizes when reading silently
- ☐ Poor reading comprehension
- ☐ Confuses letters or words
- ☐ Confuses right and left
- ☐ Writes neatly but slowly
- ☐ Difficulty copying from chalkboard
- ☐ Responds better orally than by writing
- ☐ Seems to know material, but does poor on test
- ☐ Poor general coordination
- ☐ Difficulty catching/hitting a ball
- ☐ Vision seems worse at the end of the day
- ☐ Writing uphill or downhill
- ☐ Misaligning digits in columns of numbers
- ☐ Holding reading material too close
- ☐ Difficulty with time management
- ☐ Difficulty with money concepts – making change
- ☐ Difficulty with scissors, calculator keys, etc.
- ☐ Misplaces or loses papers, objects, belongings …
- ☐ Tendency to knock things over on a desk or table
- ☐ Blurred vision at near
- ☐ Eyes hurt or tired
- ☐ Words moving on the page (run together)
- ☐ Dizziness/Nausea
- ☐ Excessive eye rubbing
- ☐ Frequent blinking
- ☐ Closing or covering one eye
- ☐ Prefers being read to
- ☐ Tilts head when writing
- ☐ Loses place while reading
- ☐ Uses finger as a marker
- ☐ Reads slowly
- ☐ Comprehension decreases over time
- ☐ Reverses letters or words
- ☐ Writes or prints poorly
- ☐ Tires easily
- ☐ Remembers better what is heard than seen
- ☐ Short attention span/loses interest
- ☐ Bumps into people/objects
- ☐ Avoids (dislikes) sports
- ☐ Burning, stinging, watery eyes
- ☐ Falls asleep when reading
- ☐ Omits small words when reading
- ☐ Inconsistent/poor sports performance
- ☐ Saying “I can’t” before trying
- ☐ Inability to estimate distances accurately
- ☐ Difficulty with colors
- ☐ Forgetful, poor memory
- ☐ Moves lips while reading
- ☐ Difficulty completing assignments on time

Patient Name: _____Date Form Completed: _____

LEISURE TIME ACTIVITIES/TELEVISION AND COMUTER VIEWING

Computer: Hours/day?____continuous or on/off Days/week?____ Viewing Distance?_____
Video Games: Hours/day?____continuous or on/off Days/week?____ Viewing Distance?_____
Television: Hours/day?____continuous or on/off Days/week?____ Viewing Distance?_____
What programs does you like the best?_____
What other activities occupy your leisure time?_____
Are there any activities you would like to participate in, but don't? No☐ Yes☐
Please explain:_____
If not, describe:_____

SCHOOL HISTORY

Did you like school? No☐ Yes☐
Specifically describe any school difficulties: _____
_____
Did you change schools often? No☐ Yes☐
If yes, when? _____
Has a grade been repeated? No☐ Yes☐
If yes, which and why? _____
Did you like to read as a child? No☐ Yes☐
Voluntarily? No☐ Yes☐
Did you read for pleasure as a child? No☐ Yes☐
If yes, what type of material?_____
As a child, what was your attitude toward reading, school your teachers, other youngsters? _____
_____
As a child and teenager was your overall schoolwork: above average ☐ average ☐ below average ☐
Which subjects were:
Above average:_____
Average:_____
Below average:_____
As a child/teen, did you need to spend a lot of time/effort to maintain this level of performance?
No☐ Yes☐
To what extent did your parents/guardian assist you with homework? _____
Did you feel you were achieving up to your potential? No☐ Yes☐
Did your teachers feel you were achieving up to your potential? No☐ Yes☐
Did your school's personnel consider you to have a learning problem? No☐ Yes☐
Did your school's personnel consider you to have a behavior problem? No☐ Yes☐

REVIEW OF SYSTEMS

In addition to our desire for a complete health history, the following review of systems is required for insurance reimbursement. Please **CIRCLE** all that apply to you – if NONE of the symptoms apply, check the box to the left (acknowledges you have reviewed the symptoms).

☐ Constitutional: Excessive appetite or thirst, Fever today, Recent weight gain or loss
☐ Cardiovascular: Chest pain, Irregular heart beat, Swelling of ankles or hands

Patient Name: _____Date Form Completed: _____

- ☐ Ears, Nose, Throat: Earaches or drainage, Hearing loss or injury, Nasal congestion, Ringing in ears, Sore mouth or throat, Vertigo
- ☐ Endocrine: Diabetes, Pituitary disease, Thyroid disease (high or low)
- ☐ Gastrointestinal: Abdominal pain, Blood in stool, Chronic diarrhea, Nausea, Reflux, Vomiting
- ☐ Genitourinary: Blood in urine, Discharge, Pain with urination, Frequent bedwetting
- ☐ Hematological/Lymphatic: Bleeding disorders, Slow healing, Swollen glands
- ☐ Musculoskeletal: Difficulty with walking, Joint pain or stiffness, Muscle pain or cramps, Frequent "growing pains"
- ☐ Neurological: Confusion, Dizziness, Numbness, Severe headache, Tingling, Tremors
- ☐ Psychiatric: Anxiousness, Depressed, Unable to concentrate
- ☐ Respiratory: Cough, Coughing up blood, Shortness of breath, Wheezing
- ☐ Skin/Breast: Birthmarks that have changed color or size, Breast lump, Excessive dryness, Rashes

MEDICAL HISTORY

Physician/s name:_____ Date of last evaluation:_____
For what reason? _____
Results and recommendations:_____
_____
Your current state of health:_____
List current medications, including vitamins and supplements:_____
_____
_____
_____
For what condition(s)?
_____
_____
Any reactions to immunization(s) or medication(s)? No☐ Yes☐ If yes, explain:_____
_____
_____
List any illnesses, bad falls, high fevers, etc.:

Age	Description	Mild/Severe	Complications

Have you been generally healthy? No☐ Yes☐ If no, explain:
_____
_____
Are there any chronic problems like ear infections, asthma, hay fever, allergies? No☐ Yes☐
If yes, please list:
_____
_____
Has a neurological evaluation been performed? No☐ Yes☐ By whom? _____
Results and recommendations:_____
Has a psychological evaluation been performed? No☐ Yes☐ By whom? _____
Results and recommendations:_____
Has an occupational therapy evaluation been performed? No☐ Yes☐ By whom? _____
Results and recommendations:_____

Patient Name: _____Date Form Completed: _____

Is there any history of the following? (Please check if it applies to the patient or a family member.)

	Patient	Relative/Parent/Sibling		Patient	Relative/Parent/Sibling
Diabetes	☐	☐Who?_____	Cataracts	☐	☐Who?_____
High Blood Pressure	☐	☐Who?_____	Glaucoma	☐	☐Who?_____
Thyroid Disease	☐	☐Who?_____	High Eye Pressure	☐	☐Who?_____
Retinal Disease	☐	☐Who?_____	Blindness	☐	☐Who?_____
Chromosomal Disease	☐	☐Who?_____	Amblyopia	☐	☐Who?_____
Learning Disability	☐	☐Who?_____	Cross or Wall eye	☐	☐Who?_____

Diagnosed/suspected Strabismus (eye turn)_____When:_____By Whom?_____
Diagnosed/suspected Amblyopia ("lazy eye")_____When:_____By Whom?_____
Diagnosed/suspected Dyslexia_____When:_____By Whom?_____
Diagnosed/suspected ADD/ADHD_____When:_____By Whom?_____
Diagnosed/suspected Food Allergies_____When:_____By Whom?_____
Diagnosed/suspected Chemical Sensitivities_____When:_____By Whom?_____
Diagnosed/suspected Head or Brain Trauma_____When:_____By Whom?_____
Diagnosed/suspected Autism Spectrum Disorder _____When:_____By Whom?_____
Diagnosed Special Needs Condition: Name:_____When:_____By Whom?_____