VISION CARE & THERAPY CENTER
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JANNA IYER, O.D.
Clinical Director

ADULT VISION QUESTIONNAIRE - EXTENDED

Please fill out this questionnaire carefully. Please return it to our office prior to your appointment.

Appointment: Day _____ Date _____ Time _____
Patient's Name: _____

GENERAL INFORMATION

Full Name: _____ Male ▫ Female ▫
Birth Date: _____ Age: _____
Home Address: _____
Cell Phone: _____ Work Phone: _____
Marital status: Single ▫ Married ▫ Divorced ▫ Widowed ▫
Were you referred to our office? Yes ▫ No ▫
If yes, whom may we thank for this referral? _____ Phone: _____
Address _____
Do you have Major Medical Insurance? Yes ▫ No ▫
If yes, who is the carrier? _____ Policy #: _____
Does the insurance cover eye examinations or glasses? Yes ▫ No ▫
Name of Insured: _____
Social Security Number: _____ Driver's License No.: _____
What is your occupation? _____ Employer: _____
Business Address: _____
Spouse's Name: _____ Occupation: _____
Spouse's Employer: _____ Phone #: _____
Business Address: _____
Please list your spouse and dependents:
Spouse _____ Birth Date _____
Dependent _____ Birth Date _____
Dependent _____ Birth Date _____
Dependent _____ Birth Date _____
Dependent _____ Birth Date _____

MEDICAL HISTORY

Date of most recent evaluation: _____ Physician's Name: _____
For what problem / condition? _____
Results and recommendations: _____
Medications currently using including vitamins and supplements: _____
For what condition(s)? _____

Are you allergic to any foods or medications? Yes ▫ No ▫

If yes, please list: _____

Current diet: Excellent ▫ Good ▫ Fair ▫ Poor ▫

Current state of health (explain): _____

Is there any history of the following? (please check if there is a history)

	Patient	Family	Who		Patient	Family	Who
Diabetes	▫	▫	_____	Strabismus / crossed eye	▫	▫	_____
Multiple Sclerosis	▫	▫	_____	Amblyopia / lazy eye	▫	▫	_____
Blindness	▫	▫	_____	Thyroid Condition	▫	▫	_____
Glaucoma	▫	▫	_____				
High Blood Pressure	▫	▫	_____	Cataracts	▫	▫	_____
				Brain Tumor	▫	▫	_____

VISUAL HISTORY

Have you had a previous vision examination? Yes ▫ No ▫

If yes, doctor's name: _____

Date of last visit: _____

Reason for examination: _____

Results and recommendations: _____

_____

Were glasses, contact lenses, or other optical devices prescribed or recommended? Yes ▫ No ▫

If so, what? _____

Do you use them? Yes ▫. No ▫

How long have you had them? _____

If used, when? _____

If not, why not? _____

If you wear contact lenses, how long have you worn them? _____

What type of lenses do you have (i.e. hard, soft, gas-permeable)? _____

What solutions do you use? _____

Members of the family who have had visual attention and the reason:

Name	Age	Visual Situation
_____	____	_____
_____	____	_____
_____	____	_____

PRESENT SITUATION

Why do you feel the need for a visual evaluation? _____

_____

How long has this problem/difficulty existed? _____

Do you experience any of the following:

	Yes	No	If yes, when?
Blurred vision at distance	□	□	
Blurred vision at near	□	□	
Red or itchy eyes	□	□	
Burning eyes	□	□	
Frequent Sties	□	□	
Watery eyes	□	□	
Eyes hurt	□	□	
Eyes feel tired	□	□	
Headaches	□	□	
Nausea associate with visual tasks	□	□	
Halos around lights	□	□	
Double vision at distance	□	□	
Double vision at near	□	□	
Tilt head during desk work	□	□	
Squinting, covering or closing one eye	□	□	
Postural changes when doing desk work	□	□	
Need for very bright light when reading	□	□	
Need for very dim light when reading	□	□	
Loss of interest or short attention span for close work	□	□	
Difficulty sustaining reading / writing	□	□	
General or visual fatigue at the end of the day	□	□	
Loss of place often when reading	□	□	
Skip lines when reading	□	□	
Repetition of letter or words when reading	□	□	
Omission of words when reading / copying	□	□	
Use of finger to keep place	□	□	
Head moves when reading	□	□	
Confusion of what is being seen or read	□	□	
Falling asleep when reading	□	□	
Silent vocalization/moving lips while reading	□	□	
Motion / car sickness	□	□	
Difficulty with reading comprehension	□	□	
Comprehension decreases over time	□	□	
Letters or words appear to move or float around when reading	□	□	
Difficulty aligning columns of numbers	□	□	
Can respond better orally than in writing	□	□	
Write or print poorly	□	□	
Poor time management	□	□	

	Yes	No	If yes, when?
Inconsistent performance in work or sports	□	□	_____
Poor general coordination / clumsiness	□	□	_____
Poor fine motor coordination	□	□	_____
Difficulties with sort-term memory	□	□	_____
Difficulties with long-term memory	□	□	_____

Comments on any items above: _____

_____

_____

_____

COMPUTERS

Do you use a computer in your work, school, or leisure time activities? Yes □ No □

If so, indicate the types of computer work you perform:

- □ Word processing
- □ Programming
- □ Data entry
- □ Internet
- □ Games / Leisure activities
- □ Other (explain): _____

How many hours do you spent in front of a computer screen each day? _____

How do your eyes feel after working at the computer? _____

- □ Where is the top of the screen located?
- □ Above your straight-ahead eye level
- □ At eye level
- □ Below eye level

What is the distance from: Your eyes to the screen? _____

Your eyes to the keyboard? _____

Your eyes to your source documents? _____

Where is the computer screen located?

- □ Directly in front of you when seated
- □ To your right
- □ To your left

Where are your source documents located?

- □ Directly in front of you when seated
- □ To your right
- □ To your left
- □ Flat (horizontal) or vertical

Do you experience any of the following lighting problems in your work area?

- □ Glare from windows or other light sources
- □ Reflections on your computer screen
- □ Difficulty reading source documents

COMPUTERS (continued)

Do you wear glasses, contact lenses, or other optical devices for computer work?

- ▫ Glasses
- ▫ Contact lenses
- ▫ Other (explain): _____

Please describe any problems you have with your vision, current glasses or contact lenses for computer work: _____

_____

_____

EMPLOYMENT OR SCHOOL

Current position: _____ Major course of study: _____

How many hours daily do you spend at a desk? _____

How many hours daily do you spend reading or studying? _____

How many hours daily do you spend working at near distances? _____

Do you feel you are achieving to your potential in work or school? Yes ▫ No ▫

Do you feel you are getting adequate return for the amount of effort you put into a task? Yes ▫ No ▫

If no, please explain: _____

Does your work or course of study demand comprehension from the written word? Yes ▫ No ▫

Describe briefly your daily activities at work or in school: _____

_____

HOBBIES/SPORTS

Describe the types of activities that comprise the majority of your leisure time: _____

_____

_____

Do you watch TV? Yes ▫ No ▫

If yes, how many hours per day? _____

How many days per week? _____

Are you seriously involved with athletics? Yes ▫ No ▫

Do you feel you are achieving up to your potential in sports/athletics? Yes ▫ No ▫

Of all the sports you have played:

List the ones in which you excel: _____

List the ones in which you do poorly/avoid: _____

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 the release of information.

I agree to permit information from, or copies of, my examination records to be exchanged with other health care providers or provided to insurance carriers upon their written request or upon the recommendation of the VISION CARE & THERAPY CENTER when it is necessary for the treatment of my visual condition, or for the processing of insurance claims. This authorization shall be valid for the duration of treatment.

_____ _____

Signature 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 related to your specific visual needs.

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us.

You may leave a message for us 24 hours a day/7 days a week. We request a minimum of 24 hours notice if you are unable to keep this appointment.

Please be on time for your examination, so that we will have the maximum opportunity to evaluate your visual status. We are looking forward to meeting you.

Thank you.

Janna Iyer, O.D.
Clinical Director