ADULT VISION QUESTIONNAIRE - EXTENDED

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

Appointment: Day_____ Date_____Time_____
Patient's Name:_____

GENERAL INFORMATION
Were you referred to our office? Yes ☐ No ☐
If yes, whom may we thank for this referral?_____Phone_____
Address_____

Full Name_____
Birth Date_____ Age_____
Home Address_____
Home Phone_____Cell Phone_____
Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐
Do you have Major Medical Insurance? Yes ☐ No ☐
If yes, who is the carrier?_____Policy #_____
Place of Employment & Position_____Work Phone_____
Business Address_____
Spouse's Place of Employment & Position_____Work Phone_____
Business Address_____

Please list the spouse and dependents:

NAME			
Spouse:	_____	Birth Date:	_____
Dependent:	_____	Birth Date:	_____
Dependent:	_____	Birth Date:	_____
Dependent:	_____	Birth Date:	_____
Dependent:	_____	Birth Date:	_____
Dependent:	_____	Birth Date:	_____

MEDICAL HISTORY
Physician's Name:_____Date of most recent evaluation:_____
For what problem/ condition?_____
Results and recommendations:_____
_____
Current state of health:_____
Medications currently using, including vitamins and supplements:_____
_____
For what condition(s)? _____

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

	Patient	Family	Who
Diabetes	☐	☐	_____
"Cross" or "Wall" Eye	☐	☐	_____
Amblyopia (lazy eye)	☐	☐	_____
Blindness	☐	☐	_____
Epilepsy or Seizures	☐	☐	_____
Brain Tumor	☐	☐	_____
Learning Disability	☐	☐	_____
Glaucoma	☐	☐	_____
Cataracts	☐	☐	_____
High Blood Pressure	☐	☐	_____
Multiple Sclerosis	☐	☐	_____
Thyroid Condition	☐	☐	_____

NUTRITIONAL INFORMATION

Current Diet: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Are there any food allergies/sensitivities? Yes ☐ No ☐

If so, explain: _____

VISUAL HISTORY

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

If so, Doctor's name? _____ Date of last evaluation: _____

Reason for examination: _____

Results and recommendations: _____

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

If yes, what? _____

Are they used? Yes ☐ No ☐ If yes, when? _____

If not used, why not? _____

How long have you had them?_____

If you wear contact 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 associated 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	☐	☐	
Inconsistent performance in work or sports	☐	☐	
Poor general coordination / clumsiness	☐	☐	
Does not judge distances accurately	☐	☐	
Poor fine motor coordination	☐	☐	
Poor organizational skills	☐	☐	
Difficulties with short-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 spend 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

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 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: _____