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ADULT VISION QUESTIONNAIRE – EXTENDED
Please fill out this questionnaire carefully.

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

GENERAL INFORMATION

Full Name: _____ Male Female

Birth Date: _____ Age: _____

Home Address: _____

Home 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 # _____

What is your occupation? _____ Employer: _____

Business Address: _____

Spouse's Name: _____ Occupation: _____

Spouse's Employer: _____ Phone # _____

Business Address: _____

Please list your spouse and dependents:

NAME

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)

	<u>Patient</u>	<u>Family</u>	<u>Who</u>		<u>Patient</u>	<u>Family</u>	<u>Who</u>
Diabetes	[]	[]	[]	Strabismus/crossed eye	[]	[]	[]
Multiple Sclerosis	[]	[]	[]	Amblyopia/lazy eye	[]	[]	[]
Blindness	[]	[]	[]	Thyroid Condition	[]	[]	[]
Glaucoma	[]	[]	[]	Cataracts	[]	[]	[]
High Blood Pressure	[]	[]	[]	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: _____

Wear glasses, contact lenses, or other optical devices prescribed or recommended? Yes [] No []

Is 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:

<u>Name</u>	<u>Age</u>	<u>Visual Situation</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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? _____

	<u>Yes</u>	<u>No</u>	<u>If yes, when?</u>
Blurred vision at distance	[]	[]	_____
Blurred vision at near	[]	[]	_____
Red or itchy eye	[]	[]	_____
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 deskwork	[]	[]	_____
Squinting, covering or closing one eye	[]	[]	_____
Postural changes when doing deskwork	[]	[]	_____
Need for very bright 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	[]	[]	_____
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	[]	[]	_____
Poor fine motor coordination	[]	[]	_____
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

Is 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 the 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 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 hours 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 Dr. Sherman 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 examinations, so that we will have the maximum opportunity to evaluate your visual status. We are looking forward to meeting you.

Thank you,

Marc H. Sherman, O.D., F.C.O.V.D.