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GOLF SPORTS VISION QUESTIONNAIRE

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

Name _____ Age _____ Date of Birth _____
Address _____
Telephone Number (home) _____ (cell) _____ (work) _____
Email Address: _____
Were you referred? Yes _____ No _____
If yes, by whom? _____ Phone: _____
Address:
_____

Do you have major medical insurance? _____
If yes, who is the carrier? _____ Policy # _____
Name of Insured _____
Social Security Number _____ Driver's License No. _____
Does your insurance cover eye examinations or eyeglasses? Yes _____ No _____
What is your occupation?
_____
Who is your employer?
_____

Please list your spouse and dependents:

Spouse _____ Birth Date _____
Dependents _____ Birth Date _____
_____ Birth Date _____

_____ Birth Date _____

_____ Birth Date _____

Please continue on the other side

MEDICAL HISTORY

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

	Patient	Family		Patient	Family
Diabetes	_____	_____	Eye Surgery	_____	_____
High Blood Pressure	_____	_____	Eye Turns	_____	_____
Thyroid Condition	_____	_____	Glaucoma	_____	_____
Cancer	_____	_____	Eye Infections	_____	_____
Blindness	_____	_____	Cataracts	_____	_____
			Macular Degeneration	_____	_____

Date of Last Visit _____ Physician's Name _____

Medications currently using:

_____

For what condition? _____

Do you have a history of allergies?.....Yes _____ No _____

If yes, please explain: _____

Do you use cigarettes/tobacco? .....Yes _____ No _____

Do you drink alcohol?.....Yes _____ No _____

Do you use other substances? .....Yes _____ No _____

VISUAL HISTORY

Date of Last Vision Exam _____ Doctor's Name _____

Reason for examination: _____

Results _____

Were glasses prescribed? .....Yes _____ No _____

Are they worn?.....Yes _____ No _____

If yes, when are they worn? _____

Any problems with your current glasses? .....Yes _____ No _____

Do you wear contact lenses?.....Yes _____ No _____

If yes, how long have you worn them? _____

What solution do you use?

_____

Do you experience any of the following?

	Yes	No	If yes, when?

Headaches	_____	_____	_____
Blurred Vision	_____	_____	_____
Double Vision	_____	_____	_____
Eyes “hurt” or “tired”	_____	_____	_____
Itchy eyes	_____	_____	_____
Burning Eyes	_____	_____	_____
Eye Drainage	_____	_____	_____
Eye redness	_____	_____	_____

SPORTS HISTORY

Golf

Which eye is your dominant eye?

_____

Do you play right handed or left handed?

_____

Do you have a visual plan when or before you hit the ball? .....Yes _____ No _____

Do you do any visual warm-up activities? .....Yes _____ No _____

Do you have any problems with balance? .....Yes _____ No _____

Are your scores as consistent as you would like? .....Yes _____ No _____

If not, what areas would you like to improve:

- ❑ Visual tracking
- ❑ Visual reaction time
- ❑ Eye-hand coordination
- ❑ Peripheral awareness
- ❑ Depth perception
- ❑ Visual endurance
- ❑ Visual concentration
- ❑ Visual relaxation
- ❑ Visual consistency
- ❑ Improve figure-ground awareness
- ❑ Decrease visual distractibility
- ❑ Block out distractions

What is your most challenging aspect of play?

- ❑ Putting
- ❑ Chipping
- ❑ Driving
- ❑ Sand traps
- ❑ Other comments _____

_____

_____

Is the level of your performance consistent throughout a round? .....Yes _____ No _____

Do you hit off of practice mats at a driving range? .....Yes _____ No _____

If so, visually, is there a difference for you on practice mats versus natural grass? Yes _____ No _____

Do you practice at a driving range at night? .....Yes _____ No _____

If so, do you perform better during the day or at night? _____

Are there any backgrounds or conditions that make it difficult for you to pick up and track the ball? _____

Is there a decrease in performance when shadows come into the field of play? .....Yes _____ No _____

Do you wear sunglasses? .....Yes _____ No _____

If yes, do they help? .....Yes _____ No _____

What color are the lenses? _____

	Very Dark				Very Light
How dark are they?	1	2	3	4	5

Do any of the following interfere with or affect your performance?

Bright/sunny days .....Yes _____ No _____

Cloudy/foggy days .....Yes _____ No _____

Dim light .....Yes _____ No _____

Shadows .....Yes _____ No _____

SPORTS HISTORY (con't)

Bright light .....Yes _____ No _____

Noises or movement .....Yes _____ No _____

Background .....Yes _____ No _____

Different ball colors .....Yes _____ No _____

OFFICE POLICIES

Fees: You are expected to pay for services and materials at the time of your examination.

Vision Service Plan and **Medical Eye Services** are billed directly. We will help you to the fullest extent possible when submitting claims to other insurance carriers.

Release Of Information and Insurance Filing:

I have read or have had read to me the above office policies and I understand them. I authorize the release of medical information to other health care providers or insurance carriers upon their written request, or upon the recommendation of the San Diego Center for Vision Care - Optometry - P.C., when it is necessary for the treatment of my visual condition or for the processing of insurance claims. I release payment of benefits either to myself, or to the San Diego Center for Vision Care - Optometry - P.C.

_____ _____

Patient's Signature Date

Thank you for your assistance. Your vision care is very important to us. Please do not hesitate to ask any questions you may have. We encourage you to call us any time if you have questions about your or your family's vision.

Please be on time for your examination.

Thank you,

The Doctors And Staff
San Diego Center for Vision Care – Optometry, P.C.

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