Optometry, P.C.
Carl G. Hillier, OD, FCOVD ◆ Melissa C. Hillier, OD, FCOVD

SPORTS VISION QUESTIONNAIRE

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

GENERAL INFORMATION

Name ______________________________ Age ______ Date of Birth ________________

Address ____

Telephone Number(s) (hm) ________________ (cell) ______________ (wk) ________________

Email Address ____

Were you referred? Yes _____ No _____

If yes, by whom? ______________________________ Phone: __________________

Address: ____

Do you have major medical insurance? __________ Do you have a flex spending account? Yes No

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 _____________________

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MEDICAL HISTORY

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

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

	Patient	Family
Cataracts	______	______

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

Which sport(s) do you play? ____

Which eye is your dominant eye? ____

Are you right handed or left handed?____

Do you have a visual plan when or before you compete? Yes _____ No _____

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

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

Is your performance 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

Other: ____

____

____

Does your performance differ when you are indoors compared to outdoors? Yes _____ No _____

Do you perform better during the day or at night? ____

Are there any backgrounds or conditions that make it difficult for you to see?

____

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	(please circle)

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

Day games Yes _____ No _____

Night games Yes _____ No _____

Dim light Yes _____ No _____

Shadows Yes _____ No _____

Bright light Yes _____ No _____

Crowd noise Yes _____ No _____

Background Yes _____ No _____

Moving players Yes _____ No _____

Crowd movement Yes _____ No _____

Uniform color Yes _____ No _____

Any other comments or questions you may have:

____

____

____

____

OFFICE POLICIES

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

Vision Service Plan/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.