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VISION REHABILITATION BRAIN INJURY QUESTIONNAIRE

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

Appointment: Day ____________________ Date ____________________ Time ____________________

PATIENT INFORMATION

Patient Name ____ Date ____________________
Address ____
Home# ____ Cell# ____
Nearest Relative ____ Phone ____________________

GENERAL INFORMATION

Were you referred? Yes _____ No _____
If yes, by whom? ____ Phone: ____________________
Address: ____
Patient's Birth Date: ____________________ Age: _______ SSI # (last 4) ____________________

Adults:

Marital status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Occupation ____ Business Phone ____________________
Business Address ____ City ______________ Zip ________
Primary Insurance _______________________________________ Policy # ____________________
Secondary Insurance _____________________________________ Policy # ____________________
Case Manager Info ____
Do you have a flex spending account? Y N
In case of emergency, contact ______________________________ Relation: ____________________

MEDICAL HISTORY

Type of injury: ____
____
Date of onset: ____
Physician's name ____ Date of most recent visit ____________
Results ____
____

MEDICAL HISTORY (con't)

Medications currently using ____
____
For what condition(s)? ____
____
Do you have a history of allergies? ....Yes _____ No ______

If yes, please explain: ____
Has a neurological evaluation been performed? ....Yes _____ No ______
If yes, by whom? ___________________________________ Date ______________
Results ____
Has a psychological evaluation been performed? ....Yes _____ No ______
If yes, by whom? ___________________________________ Date ______________
Results ____
Has a speech and language evaluation been performed? ....Yes _____ No ______
If yes, by whom? ___________________________________ Date ______________
Results ____
Is there any history of the following? (please check if there is a history)

	Patient	Family
High blood pressure	_______	_______
Diabetes	_______	_______
Thyroid condition	_______	_______
Multiple sclerosis	_______	_______
Brain tumor	_______	_______
Stroke	_______	_______
Traumatic brain injury	_______	_______

	Patient	Family
Glaucoma	_______	_______
Cataracts	_______	_______
Blindness	_______	_______
Strabismus	_______	_______
Amblyopia	_______	_______
Macular Degeneration	_______	_______

Do you use cigarettes/tobacco? ....Yes _____ No ______
Do you drink alcohol? ....Yes _____ No ______
Do you use other substances? ....Yes _____ No ______

VISUAL HISTORY

Have you had a previous vision examination?...Yes _____ No ______
If yes, doctor's name ______________________________
Date of last visit _________________________________
Reason for examination: ____
Results ____

Are any of the following experienced by the patient? Some may be "unknown" or "not applicable".

	Yes	No	Unknown/Not Applicable
Brightness is bothersome	______	______	______
Motion sickness	______	______	______
Eye ache	______	______	______
Headaches	______	______	______
Blurred vision	______	______	______
Eye redness	______	______	______
Double vision	______	______	______
One eye turns in, out, up, or down	______	______	______

VISUAL HISTORY (con't)

	Yes	No	Unknown/Not Applicable
Burning eyes	______	______	______
Eye drainage	______	______	______
Itching eyes	______	______	______

Delayed dressing skills	_____	_____	_____
Difficulty following a series of directions	_____	_____	_____
Difficulty using both sides of the body together	_____	_____	_____
Movement of objects in the environment are bothersome	_____	_____	_____
Fluorescent light is bothersome	_____	_____	_____
Patterned wallpaper or carpets are bothersome	_____	_____	_____
Grocery stores or malls are difficult to be in	_____	_____	_____
Head moves when reading	_____	_____	_____
Lose place often when reading	_____	_____	_____
Use finger to keep place	_____	_____	_____
Short attention span for close work	_____	_____	_____
Skip words frequently when reading	_____	_____	_____
Orient drawings poorly on page	_____	_____	_____
Squinting, covering or closing one eye	_____	_____	_____
Tilt head during desk work	_____	_____	_____
Fatigue easily	_____	_____	_____
Hold books too closely	_____	_____	_____
Avoid near tasks	_____	_____	_____
Dislike heights	_____	_____	_____
Awkward, poor balance	_____	_____	_____
Difficulty with peripheral vision	_____	_____	_____
Memory difficulties	_____	_____	_____

Does vision hinder activities of daily living?..Yes ____ No _____

If yes, please explain: ____

____

Have eyeglasses or contacts ever been prescribed? ....Yes ____ No _____

Bifocal ____________ Single Vision ______________ Tinted _____________ Date ____________

If so, are they worn?..Yes ____ No _____

Are they for distance? ....Yes ____ No _____

Are they for near?..Yes ____ No _____

Are they for full-time use?..Yes ____ No _____

Has there ever been any visual rehabilitation? ....Yes ____ No _____

If yes, when? ____

Please explain: ____

____

EMPLOYMENT/EDUCATION INFORMATION (IF APPLICABLE)

What is current employment position? ____

If a student, what is the major course of study? ____

How many hours daily are spent at a desk? ____

How many hours daily are spent working at near distance? ______________________________

How many hours daily are spent reading/studying? ____________________________________

How many hours daily are spent with a computer? ____________________________________

LIFESTYLE

What activities are engaged in? (please explain)

What activities can no longer be engaged in due to visual difficulties? (please explain)

What do you hope the Visual Rehabilitation Program can do for you? (please explain)

If you have any questions that you would like us to answer during your evaluation, please write them on the back of this sheet.

RELEASE OF INFORMATION AND INSURANCE FILING

I agree to permit information from, or copies of, my examination records to be forwarded 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 to myself or to the San Diego Center for Vision Care, Optometry - P.C.

__________________________________ __________________________________

Signature Date

For Minors:

I hereby give my permission to the San Diego Center for Vision Care, Optometry - P.C. to treat:

______________________________.

(Child's Name)

__________________________________ __________________________________

Parent's or Guardian's Signature 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 relate the current visual skills to any specific needs.

Please be on time for your examination.

Thank you.

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