SAN DIEGO CENTER for VISION CARE-

OPTOMETRY, P.C.

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VISUAL INFORMATION PROCESSING EVALUATION (Adult)

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

Were you referred? Yes _____ No _____

If yes, by whom? _____ Phone: _____

Address: _____

Full Name: _____ Nickname _____

Male ____ Female ____ Birth Date: _____ Age: _____ years _____ months

Home Address _____ City _____ Zip_____

Home Phone_____ Cell Phone _____

Occupation_____ Email Address _____

Spouse's Name _____ Occupation _____

Do you have Major Medical Insurance? _____ Do you have a flex spending account? Y N

If so, who is the carrier? _____ Policy # _____

Name of Insured: _____

Social Security Number (last 4 #'s) _____ Driver's License No. _____

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Result _____

Medications currently using: _____

For what condition? _____

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

	You	Family		You	Family
High Blood Pressure	_____	_____	Glaucoma	_____	_____
Diabetes	_____	_____	Cataract	_____	_____
Thyroid Condition	_____	_____	Blindness	_____	_____
Multiple Sclerosis	_____	_____	Strabismus	_____	_____
Brain Tumor	_____	_____	Amblyopia	_____	_____
Stroke	_____	_____	Chromosomal Imbalance	_____	_____

MEDICAL HISTORY (continued)

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

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

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

Are there other health problems? ..... Yes _____ No _____

If yes, please explain _____

Are there any chronic problems like ear infections, asthma, hay fever, allergies? ..... Yes _____ No _____

If yes, please list _____

Current Diet: Excellent _____ Good _____ Fair _____ Poor _____

Has there been exposure to toxic mold, substances or fumes? ..... Yes _____ No _____

List illnesses, concussions, bad falls, high fevers, ear infections, etc.:

Age	Severe	Mild	Complications

Has a speech / language evaluation been performed? ..... Yes _____ No _____

By whom? _____ When? _____

Results _____

Has an occupational therapy evaluation been performed? ..... Yes _____ No _____

By whom? _____ When? _____

Results _____

Has a neurological evaluation been performed? ..... Yes _____ No _____

By whom? _____ When? _____

Results _____

Has a psychological evaluation been performed? ..... Yes _____ No _____

By whom? _____ When? _____

Results _____

PREVIOUS VISION EXAMINATIONS

Have you had a previous vision examination? ..... Yes _____ No _____

If yes, doctor's name: _____

Date of last visit: _____

Reason for examination: _____

Results: _____

Were glasses or contact lenses ever prescribed? ..... Yes _____ No _____

If yes, Bifocal? _____ Single-vision? _____ Date Prescribed _____

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

When are they worn? _____

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

Are they for near? ..... Yes _____ No _____

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

Were contact lenses ever prescribed? ..... Yes _____ No _____

If you wear contact lenses, how long have you worn them? _____

Have you been told you could not wear contact lenses? ..... Yes _____ No _____

If you do not wear contact lenses, are there times you would benefit from them? .... Yes _____ No _____

Sports: ..... Yes _____ No _____

Social Events:..... Yes _____ No _____

Appearance: ..... Yes _____ No _____

If you were prescribed contact lenses, have you stopped wearing them? ..... Yes _____ No _____

If yes, why did you stop? _____

Have you had refractive surgery? ..... Yes _____ No _____

Have you had any other eye surgeries? ..... Yes _____ No _____

Members of the family who have had visual attention and the reason:

Name	Age	Visual Situation
_____	_____	_____
_____	_____	_____

Has Vision Therapy been prescribed ..... Yes _____ No _____

Has Vision Therapy been done? ..... Yes _____ No _____

If yes, for how long? _____

PRESENT SITUATION

Do you experience any of the following?:	Yes	No	If yes, when?
Headaches	_____	_____	_____
Blurred vision	_____	_____	_____
Double vision	_____	_____	_____
Eyes “feel tired”, “ache” or “hurt”	_____	_____	_____
You fatigue easily	_____	_____	_____
Brightness is bothersome	_____	_____	_____
Fluorescent lights are bothersome	_____	_____	_____
Patterned wallpaper or carpets are bothersome	_____	_____	_____
Grocery stores or malls are difficult to be in	_____	_____	_____
Movement of objects in the environment is bothersome or distracting	_____	_____	_____
There is difficulty with peripheral vision	_____	_____	_____
One eye turns in, out, up or down	_____	_____	_____
Squinting, covering or closing one of your eyes	_____	_____	_____
Frequently blinking	_____	_____	_____
Frequently rubbing eyes	_____	_____	_____
Frequently reddened eyes	_____	_____	_____
Eyes itch	_____	_____	_____
Excess mucus or tears	_____	_____	_____
Motion sickness or dizziness (circle one or both)	_____	_____	_____
Uncomfortable watching 3-D movies	_____	_____	_____
You dislike heights	_____	_____	_____
Difficulty catching or hitting a ball	_____	_____	_____
Poor motor or balance coordination	_____	_____	_____

VISUAL HISTORY (CONTINUED)	Yes	No	If yes, when?
Difficulty using both sides of the body together	_____	_____	_____
Delayed dressing skills	_____	_____	_____
Moving your head close to paper when reading or writing	_____	_____	_____
Tilting your head when reading or writing	_____	_____	_____
Your head moves when reading	_____	_____	_____
Confusing letters or words (circle one or both)	_____	_____	_____
Reversing letters or words (circle one or both)	_____	_____	_____
Words appear to move around on the page	_____	_____	_____
Skipping, rereading or omitting words (circle)	_____	_____	_____
You lose your place while reading	_____	_____	_____
You use your finger as a marker when reading	_____	_____	_____
Vocalizing when you are reading silently	_____	_____	_____
Reading slowly	_____	_____	_____
Poor reading comprehension	_____	_____	_____
There are memory difficulties	_____	_____	_____
Difficulty following a series of directions	_____	_____	_____
Short attention span when reading or writing	_____	_____	_____
Poor spelling	_____	_____	_____
Writing or printing poorly	_____	_____	_____
Difficulty completing your assignments	_____	_____	_____
Avoiding activities that are within arm's reach	_____	_____	_____

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

If yes, please explain: _____

_____

"SCREEN TIME"

This is the amount of time you look at a TV, computer, iPad or tablet, "Smart Phone", Kindle, etc.

Academic/Work:	Days per week_____	Hours per day____	Distance from eyes to screen_____
Recreational:	Days per week_____	Hours per day____	Distance from eyes to screen_____
Social/texting:	Days per week_____	Hours per day____	Distance from eyes to screen_____

Do you access social or recreational screen time while working or studying? Yes _____ No _____

What are the total hours you are in front of a screen? Hours per day _____

Is there visual or physical discomfort with computer use? Yes _____ No _____

COMPUTERS

Where is the computer screen located?

- ☐ Directly in front of you when seated
- ☐ To your right
- ☐ To your left

Where is the top of the screen located?

- ☐ Above your straight-ahead eye level
- ☐ At eye level
- ☐ Below eye level

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 or contact lenses for computer work?

- ☐ glasses
- ☐ contact lenses

EMPLOYMENT OR SCHOOL

Current position _____ Major course of study _____

How many hours daily do you spend reading/studying without a computer? _____

Are you achieving to your potential in work or school? ..... Yes _____ No _____

Are you getting adequate return for the amount of effort you put into a task? ..... Yes _____ No _____

Describe briefly your daily activities at work or in school: _____

_____

HOBBIES

Describe the types of activities that comprise the majority of your spare time: _____

_____

Are you seriously involved with athletics? ..... Yes _____ No _____

Do you feel you are achieving up to your athletic potential? ..... Yes _____ No _____

Of all the sports you have played:

List the ones in which you excel: _____

List the ones in which you do not excel: _____

Do you have any additional comments, questions or concerns?

_____

_____

_____

What are your visual goals?

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

_____.
(Name)

_____ _____
Signature Date

Would you be interested in online telemedicine consultations or conferences in the future?
Yes ____ No ____ Maybe ____

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.