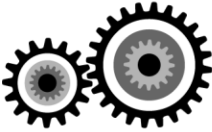

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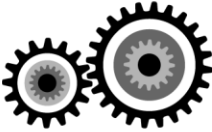
Patient: Date:

SYMPTOM	NEVER	SELDOM	OCCASIONAL	FREQUENTLY	ALWAYS
1. Distance vision blurred even with glasses	☐	☐	☐	☐	☐
2. Near vision blurred even with glasses	☐	☐	☐	☐	☐
3. Clarity of vision changes or fluctuates	☐	☐	☐	☐	☐
4. Poor night vision or driving at night	☐	☐	☐	☐	☐
5. Eye discomfort/sore eyes/eyestrain	☐	☐	☐	☐	☐
6. Headaches or dizziness after using eyes	☐	☐	☐	☐	☐
7. Eye fatigue/tired after using eyes all day	☐	☐	☐	☐	☐
8. Feel “pulling” around the eyes	☐	☐	☐	☐	☐
9. Double vision – worse when tired	☐	☐	☐	☐	☐
10. Have to close or cover one eye to see	☐	☐	☐	☐	☐
11. Print moves in/out of focus when reading	☐	☐	☐	☐	☐
12. Indoor lighting uncomfortable/glare	☐	☐	☐	☐	☐
13. Outdoor light too bright, need sunglasses	☐	☐	☐	☐	☐
14. Car sickness/ motion sickness	☐	☐	☐	☐	☐
15. Eyes feel “dry” or sting	☐	☐	☐	☐	☐
16. Excessive eye watering	☐	☐	☐	☐	☐
17. Have to rub eyes frequently	☐	☐	☐	☐	☐
18. Clumsiness/misjudges where objects are	☐	☐	☐	☐	☐
19. Lack of confidence walking/stumbles	☐	☐	☐	☐	☐
20. Poor handwriting (space, size, legibility)	☐	☐	☐	☐	☐
21. Side vision distorted/objects move position	☐	☐	☐	☐	☐
22. Tunnel vision or objects jump in and out of view	☐	☐	☐	☐	☐
23. Avoid crowds/can’t tolerate “visually busy” places	☐	☐	☐	☐	☐
24. Short attention span/ distracted when reading	☐	☐	☐	☐	☐
25. Difficulty/ slowness w/ reading & writing	☐	☐	☐	☐	☐
26. Poor reading comprehension	☐	☐	☐	☐	☐
27. Confusion of words/ skips words when reading	☐	☐	☐	☐	☐
28. Lose place/ have to use finger when reading	☐	☐	☐	☐	☐



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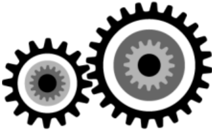
Patient's Name:			
Phone number(s):			
Occupation/Grade:		Patient's Birthdate:	
Employer/ School:			
Home Address:			
City/State/Zip:			
Email Address:			
Current Medications:			
List any medications to which patient is allergic:			
How did you hear about us?			

X________________________________I have read and agree to the Notice of Privacy Practices

Thank you for taking time to fill out this form. We look forward to helping you!

Additional Patient History on next page….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Patient's Additional History

Patient's Name:		Date:	

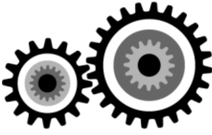
Have you noticed any signs/symptoms that concern you?	YES ☐ NO☐
If yes, please explain:	
Are there any activity restrictions because of vision:	YES ☐ NO☐
If yes, please explain:	

How are you doing in school or work?	Well ☐	Below Potential☐	Poorly☐
If yes, please explain any difficulties:			
Visual demands at work: (reading, computer, etc.)			

Do you wear glasses, contact lenses, and/or use a special optical device?			YES ☐ NO☐
If yes, what?		Do you wear them?	YES ☐ NO☐
If yes, when?		If no, why?	

Health History:

Any serious/major falls, injuries, concussions or TBI's?	YES ☐ NO☐
Explain:	
List any serious or chronic illness:	
Have you had any surgeries? By Whom? For what?	



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Have you been through a traumatic family situation?	YES ☐ NO☐
If yes, please explain:	
Has anyone in the immediate family had a learning problem?	YES ☐ NO☐
Explain:	
Have you had an occupational/speech/physical therapy evaluation by performed?	YES ☐ NO☐

By Whom?		Results:	

Recreation, Leisure and Devices:

Please list any recreational/sport activities that you participate in:	
Visual demands for recreational/sport activities:	
Do you wear protective eyewear for your sport?	YES ☐ NO☐
How many hours each day do you use a computer at work?	
How many hours each day do you use a computer at home?	
How much television do you watch each day?	
How much time do you spend looking at a smartphone or tablet a day?	

Do you read for fun?	YES ☐ NO☐	How much daily?	