



Brain & Eye Connection Vision Clinic, PC

Carolanne H. Roach, OD 1530 SW 89th St, Bldg D-2, OKC, OK 73159 (405) 703-3163
www.BrainAndEyeConnection.com Fax (405) 691-6547 visionclinic@brainandeyeconnection.com

ADULT VISION QUESTIONNAIRE

Please fill out this questionnaire carefully. Put N/A if not applicable or unknown.
Please return it to our office prior to your appointment. **THANK YOU.**

Initial Appointment: Day _____ Date _____ Time _____
Name of person filling out this form: _____ Relation to Patient: _____

PATIENT INFORMATION

Full Name: _____ Male Female
Birth Date: _____ Age: _____
Home Address: _____ City: _____ State/Zip: _____
Home Phone: _____ Work Phone: _____
Marital status: Single Married Divorced Separated Widowed
Social Security Number: _____ Driver's License No.: _____
What is your occupation? _____ Employer: _____

GENERAL INFORMATION

Business Address: _____ City: _____ State/Zip: _____
Spouse's Name: _____ Occupation: _____
Spouse's Employer: _____ Phone #: _____
Business Address: _____ City: _____ State/Zip: _____

Please list the names and birth dates of your family members:

Spouse	_____	Birth Date	_____
Dependent	_____	Birth Date	_____
Dependent	_____	Birth Date	_____
Dependent	_____	Birth Date	_____
Dependent	_____	Birth Date	_____

REFERRAL INFORMATION

Were you referred to our office? Yes No
If yes, who may we thank for this referral? _____ Phone: _____
Address: _____
If not referred, how did you hear about us? _____

MEDICAL HISTORY

Date of most recent evaluation: _____ Physician's Name: _____
Physician's Address: _____ City: _____ State/Zip: _____
Reason for last visit? _____
Results and recommendations: _____

Medications currently using including vitamins and supplements: _____

For what condition(s)? _____

Are you allergic to any foods or medications? Yes No

If yes, please list: _____

Do you have seasonal chronic or any other allergies ? Other: _____

Current state of health (explain): _____

GENERAL HEALTH INFORMATION

List all significant illnesses, bad falls, high fevers, head injuries, car wrecks, etc.:

<u>Description</u>	<u>Age</u>	<u>Severity</u>	<u>Complications</u>

SYSTEMIC HEALTH INFORMATION

Do you have or have you had any problems in the following areas:

Cancer	<input type="checkbox"/>	Weight Loss/Gain	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	Endocrine glands	<input type="checkbox"/>	Heart or Vascular	<input type="checkbox"/>
Muscle pain	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	Gastrointestinal	<input type="checkbox"/>
Bladder	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>
Autoimmune disorder	<input type="checkbox"/>	Chromosomal imbalance	<input type="checkbox"/>	Other:	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Type: _____		Diagnosed when? _____	

If you checked one or more of the above please explain further: _____

FAMILY HISTORY INFORMATION

Has anyone in your immediate family had or currently have any problems in the following areas:

(If so, please list the family member(s) affected)

Diabetes	<input type="checkbox"/>	_____	Blindness	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	_____	Congenital cataract	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	_____	Strabismus (eye turn)	<input type="checkbox"/>	_____
Kidney disease	<input type="checkbox"/>	_____	Amblyopia (lazy eye)	<input type="checkbox"/>	_____
Thyroid disease	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	_____	Retinal Detachment	<input type="checkbox"/>	_____
Rheumatoid Arthritis	<input type="checkbox"/>	_____	Other	<input type="checkbox"/>	_____

If other please explain: _____

VISUAL HISTORY

Have you had a previous vision examination? Yes No

If yes, doctor's name: _____

Date of last visit: _____

Reason for examination: _____

Results and recommendations: _____

Were glasses, contact lenses, or other optical devices prescribed or recommended? Yes No

If so, what? _____

Do you use them? Yes No

How long have you had them? _____

If used, when/for what reason? _____

If not, why not? _____

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

What type of contact lenses do you have (i.e. hard, soft, gas-permeable)? _____

What cleaning solutions do you use? _____

Why do you feel the need for a visual evaluation? _____

How long has this problem/difficulty existed? _____

COMPUTERS

Do you use a computer in your work, school, or leisure time activities? Yes No

If so, indicate the types of computer work you perform:

- Word processing
- Programming
- Data entry
- Internet
- Games / Leisure activities
- Other (explain): _____

How many hours do you spent in front of a computer screen each day? _____

How do your eyes feel after working at the computer? _____

Where is the top of the screen located?

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

What is the distance from: Your eyes to the screen? _____

Your eyes to the keyboard? _____

Your eyes to your source documents? _____

Where is the computer screen located?

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

Where are your source documents located?

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

Are your source documents?

- Flat on the desk
- Vertical on a stand

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, contact lenses, or other optical devices specific for computer work?

- Glasses
- Contact lenses
- Other (explain): _____

Please describe any problems you have with your vision, current glasses or contact lenses for computer work: _____

QUALITY OF LIFE SURVEY

Place a check in the box that corresponds to the frequency of each symptom you have.

Symptoms	Never	Seldom (1-2x/mo)	Occasionally (3-5x/mo)	Frequently (2-3x/wk)	Always (4-5x/wk)
Blur when looking at near	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches with near work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Words run together when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning, itchy, watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Falling asleep when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision is worse at the end of the day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skipping/repeating lines when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy/Nausea with near work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head tilt/closing 1 eye when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty focusing/changing focus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoiding near work/reading/writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Omitting small words when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing up/down hill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty aligning columns of numbers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with reading comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inconsistent performance in work or sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Postural changes when doing deskwork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble keeping attention on reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficult to stay on task	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty trying new things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Avoiding physical activity that requires coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor eye/hand or fine motor coordination (i.e. handwriting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do not judge distances accurately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clumsy, knock things over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor time management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do not count or make change well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lose belongings/things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Car/motion sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forgetful/poor memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Office Use Only	Total	_____	_____	_____	_____

HAVE YOU EVER NOTICED ANY OF THE FOLLOWING SYMPTOMS:

	<u>Yes</u>	<u>No</u>	<u>If yes, Describe:</u>
Blurred vision at distance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent Sties	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes hurt	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes feel tired	<input type="checkbox"/>	<input type="checkbox"/>	_____
Halos around lights	<input type="checkbox"/>	<input type="checkbox"/>	_____
Need for very bright light when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Need for very dim light when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
General or visual fatigue at the end of the day	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of place often when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reading is slow or laborsome	<input type="checkbox"/>	<input type="checkbox"/>	_____
Repetition of letters or words when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Use of finger to keep place	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head moves when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Confusion of what is being seen or read	<input type="checkbox"/>	<input type="checkbox"/>	_____
Silent vocalization/moving lips while reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Comprehension decreases over time	<input type="checkbox"/>		_____
Can respond better orally than in writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulties with sort-term memory	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulties with long-term memory	<input type="checkbox"/>	<input type="checkbox"/>	_____
Comments on any items above:			_____

EMPLOYMENT OR SCHOOL

What is your current employment position? _____
If a student, what is the major course of study? _____
How many hours daily do you spend at a desk? _____
How many hours daily do you spend reading or studying? _____
How many hours daily do you spend working at near distances? _____
Do you feel you are achieving up to your potential in work or school? Yes No
Do you feel you are getting adequate return for the amount of effort you put into a task? Yes No
If no, please explain: _____
Does your work or course of study demand comprehension from the written word? Yes No
Describe briefly your daily activities at work or in school: _____

HOBBIES/SPORTS

Describe the types of activities that comprise the majority of your leisure time: _____
Do you watch TV? Yes No
If yes, how many hours per day? _____ How many days per week? _____
Are you seriously involved with athletics? Yes No
Do you feel you are achieving up to your potential in sports/athletics? Yes No
Of all the sports you have played:
List the ones in which you excel: _____
List the ones in which you do poorly/avoid: _____