



# Brain & Eye Connection Vision Clinic, PC

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Please return it to our office at or prior to your appointment. **THANK YOU.**

Name of person filling out this form: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

## PATIENT INFORMATION

Patient's Full Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Male  Female

Social Security Number: \_\_\_\_\_ Driver's License No.: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Okay to contact by email:  Yes  No

Marital status: Single  Married  Divorced  Separated  Widowed

What is your occupation? \_\_\_\_\_ Employer: \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

## GENERAL INFORMATION

Spouse's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

Spouse's Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

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

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 head or brain injury/accident: \_\_\_\_\_

Type of injury/accident: Motor vehicle  Fall  Blow to head  Industrial Accident

Medication-related  Drug abuse  Poison or toxic substance  Carbon dioxide

Drowning  Cord around neck  Stroke  Aneurysm  Hemorrhage  IED/Blast

Other: \_\_\_\_\_

WHAT PART OF YOUR HEAD WAS AFFECTED? (check all that apply):

Forehead  Right side  Left side  Back of head  Top of head  Face

Was the injury OPEN HEAD (bleeding)  or CLOSED HEAD (non-bleeding)

Did you lose consciousness? Yes  No  If yes, for how long? \_\_\_\_\_

Were you in a coma? Yes  No  If yes, how long? \_\_\_\_\_

**SYMPTOMS IMMEDIATELY FOLLOWING ACCIDENT/INJURY: (check all that apply)**

Double vision  Headache  Blurred vision  Pain in or around eyes  Dizziness   
Vomiting  Flashes of light  Disorientation  Loss of balance  Neck pain/whiplash   
Loss of memory  Restricted field of view  Restricted motion

Other: \_\_\_\_\_

**INITIAL TREATMENT**

When did you first see a doctor regarding your accident/injury? \_\_\_\_\_

Name of Doctor: \_\_\_\_\_ Specialty: \_\_\_\_\_

Where were you seen? \_\_\_\_\_

Were you hospitalized? Yes  No  How long? \_\_\_\_\_

What did the initial treatments consist of? \_\_\_\_\_

What prognosis/recommendations were you given? \_\_\_\_\_

Were you given medications? Yes  No  Medication: \_\_\_\_\_

For what condition(s)? \_\_\_\_\_

List any other medications, including vitamins and supplements used at the current time: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SUBSEQUENT/OTHER PROFESSIONALCARE**

**WHAT TYPES OF PROFESSIONAL CARE HAVE YOU RECEIVED OR ARE YOU CURRENTLY RECEIVING AND THE DATE OF YOUR LAST EXAM?**

Primary Physicians Name: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

Physiatrist Name (Rehab doctor): \_\_\_\_\_ Date: \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

Has a neurological evaluation been performed? Yes  No

Neurologist Name: \_\_\_\_\_ Date: \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

Has a psychological evaluation been performed? Yes  No

Neuropsychologist Name: \_\_\_\_\_ Date: \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

Psychologist / Psychiatrist Name: \_\_\_\_\_ Date: \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

Has physical therapy been recommended? Yes  No

Physical Therapist Name: \_\_\_\_\_ Date: \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

Has a speech and language evaluation been performed? Yes  No

Speech / Language Therapist Name: \_\_\_\_\_ Date: \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

Osteopathic Physicians Name: \_\_\_\_\_ Date: \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

Has an occupational therapy evaluation been performed? Yes  No

Occupational Therapist Name: \_\_\_\_\_ Date: \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

Other / Name: \_\_\_\_\_ Date: \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

\_\_\_\_\_

**SYSTEMIC HEALTH INFORMATION**

Check yes if you currently have or have had any significant problems in the following areas:

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

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

Are you allergic to any foods or medications? Yes  No

If yes, please list: \_\_\_\_\_

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

**FAMILY HISTORY INFORMATION**

Has anyone in your immediate family had or currently have any problems in the following areas:  
(If yes, please list the family member(s) affected)

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

If other please explain: \_\_\_\_\_

**VISUAL HISTORY**

Have you had a previous vision evaluation? Yes  No  Date of last evaluation: \_\_\_\_\_

If yes, doctor's name: \_\_\_\_\_ Address: \_\_\_\_\_

Reason for examination: \_\_\_\_\_

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

If yes, what? \_\_\_\_\_

Are they used? Yes  No  If yes, when? \_\_\_\_\_

If no, why not? \_\_\_\_\_

Were any additional tests, treatments, or therapies recommended? Yes  No

If yes, what? \_\_\_\_\_

Did you undergo these treatments? Yes  No  Explain: \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

Why do you feel the need for a vision evaluation today? \_\_\_\_\_

How long has this problem/difficulty existed? \_\_\_\_\_

## 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"/>
Dizziness/Nausea	<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"/>
Hold reading material too close	<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"/>
<b>Office Use Only</b>	<b>Total</b>	_____	_____	_____	_____

**DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING:** (Please make a check under the Prior to injury? section if these symptoms occurred previous to your injury as well as currently.)

	<u>Yes</u>	<u>No</u>	<u>Prior to injury?</u>	<u>Describe</u>
Eyes ache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes pull or tug	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty moving or turning eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pain with movement of eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes twitch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pain in or around eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eye redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Brightness is bothersome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blurred vision at distance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
One eye turns in, out, up or down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Movement of objects in the environment is bothersome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fluorescent light is bothersome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Patterned wallpaper or carpets are bothersome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Head moves when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lose place often when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Discomfort when reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Loss of concentration when doing close work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Orient writing/drawing poorly on page	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Postural changes when doing deskwork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty with peripheral vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Objects jump in and out of field of view	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reduced depth perception	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tunnel vision / Loss of visual field	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Flashes of light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty with dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty with bathing / personal hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty following a series of directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty using both sides of the body together	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dislike heights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Awkward, poor balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Confusion / disorientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Get lost often	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bothered by noises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bothered by touch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty remembering things heard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty remembering things seen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty remembering name of objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty remembering people's names	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty recalling information known in the past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty remembering formerly familiar people / objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty performing tasks that were formerly easy / routine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty with numbers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**HEADACHES**

Do you currently or recently after head/brain injury experience headaches? Yes  No

Did you have these types of headaches before the injury/incident? Yes  No

Where are the headaches located? Forehead  Temples  Top of head  Back of head   
Neck & Shoulders  One side of head  Around eyes  Beneath cheeks

Is the pain (check all that apply): sharp  dull  long-lasting  temporary

Describe headaches \_\_\_\_\_

Does anything make the headaches go away: Yes  No

If so, explain: \_\_\_\_\_

**EMPLOYMENT/EDUCATION INFORMATION (IF APPLICABLE)**

What is your current status?  Employed  Part Time Student  Full Time Student

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

How many hours daily do you spend at a desk? \_\_\_\_\_ Reading or studying? \_\_\_\_\_

How many hours daily do you spend working at near distances? \_\_\_\_\_ At a computer? \_\_\_\_\_

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: \_\_\_\_\_

**LIFESTYLE**

Do you feel your vision interferes with activities of daily living? Yes  No

If yes, please explain (please include effects involving home, work, hobbies social and personal relationships): \_\_\_\_\_

What activities comprise the majority of your daily life since your accident/injury? \_\_\_\_\_

What activities can you no longer engage in due to your visual or other difficulties? \_\_\_\_\_

What other changes/limitations in your daily life do you attribute to your accident/injury? \_\_\_\_\_

What do you hope a Visual Rehabilitation Program can do for you? \_\_\_\_\_

I hereby give permission to Brain & Eye Connection Vision Clinic, PC to treat me, release appropriate information to third parties for reimbursement purposes, and also accept any and all financial responsibilities for services provided.

I acknowledge that the Notice of Privacy Practices is available at [www.brainandeyeconnection.com](http://www.brainandeyeconnection.com) or the office location where treatment is conducted and that I have read and understood the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date