

ADULT VISION QUESTIONNAIRE - EXTENDED

Please fill out this questionnaire carefully and bring it with you to your appointment.

THANK YOU.

GENERAL INFORMATION:

Full Name: _____ Male Female

Birth Date: _____ Age: _____

Home Address: _____

Home Phone: _____ Email Address: _____

Marital status: Single Married Divorced Widowed

Reason for visit: _____

Were you referred to our office? Yes No

If yes, whom may we thank for this referral? _____ Phone: _____

Address _____

Do you have Major Medical Insurance? Yes No

If yes, who is the carrier? _____ Policy #: _____

Does the insurance cover eye examinations or glasses? Yes No

Name of Insured: _____

Social Security Number: _____ Driver's License No.: _____

What is your occupation? _____ Employer: _____

Business Phone: _____

Please list the names and ages of your and children:

NAME

Dependent _____ Age: _____

Dependent _____ Age: _____

Dependent _____ Age: _____

Dependent _____ Age: _____

MEDICAL HISTORY:

Physician's Name: _____ Phone Number: _____

Physician's Address: _____

Please list the medications you are currently using including vitamins and supplements:

1. _____ Condition: _____

2. _____ Condition: _____

3. _____ Condition: _____

4. _____ Condition: _____

5. _____ Condition: _____

Please list any illnesses, bad falls, high fevers or ear infections, etc.:

<u>Age</u>	<u>Severe</u>	<u>Mild</u>	<u>Complications</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Was there any related trauma, disease, or condition that preceded or accompanied the onset of your eye turn? Yes No

If yes, please explain: _____

Has a neurological evaluation been performed? Yes No

If yes, by whom? _____

Results and Recommendations: _____

Has a psychological evaluation been performed? Yes No

If yes, by whom? _____

Results & Recommendations: _____

Has an occupational therapy evaluation been performed? Yes No

If yes, by whom? _____

Results & Recommendations: _____

Medical History: Please mark an "X" on conditions that apply.

1. _____ Crossed Eyes.
2. _____ Amblyopic eye (laze eye).
3. _____ Learning Disability.
4. _____ Dyslexia.
5. _____ ADD/ADHD.
6. _____ Asperger's Syndrome/Autism.
7. _____ Epilepsy/Seizure.
8. _____ Diabetes.
9. _____ High Blood Pressure.
10. _____ Glaucoma.
11. _____ Multiple Sclerosis.
12. _____ Thyroid Condition
13. _____ Brain Tumor/Brain Injury
14. _____ Other. If yes, please list: _____
15. _____ Allergies to foods or medications. If yes, please list: _____

Family History: Please mark an "X" on all conditions that apply and list the family member who has the following condition?

- 16. _____ Crossed Eyes. Family Member: _____
- 17. _____ Amblyopic (laze eye). Family Member: _____
- 18. _____ Learning Disability. Family Member: _____
- 19. _____ Dyslexia. Family Member: _____
- 20. _____ ADD/ADHD. Family Member: _____
- 21. _____ Asperger's Syndrome/Autism: Family Member : _____
- 22. _____ Epilepsy/Seizure. Family Member: _____
- 23. _____ Chromosomal Imbalance. Family Member: _____
- 24. _____ Diabetes. Family Member: _____
- 25. _____ High Blood Pressure. Family Member: _____
- 26. _____ Glaucoma. Family Member: _____
- 27. _____ Multiple Sclerosis. Family Member: _____
- 28. _____ Near-Sighted. Family Member: _____
- 29. _____ Far-Sighted. Family Member: _____
- 30. _____ Other. Family Member: _____

OCULAR 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? _____

If not, why not? _____

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

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

What solutions do you use? _____

HAVE YOU EVER NOTICED THE FOLLOWING:

	<u>Yes</u>	<u>No</u>	<u>If yes, when and how often?</u>
Blurred vision at distance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred vision at near	<input type="checkbox"/>	<input type="checkbox"/>	_____
Red or itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burning eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent Sties	<input type="checkbox"/>	<input type="checkbox"/>	_____
Watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes hurt	<input type="checkbox"/>	<input type="checkbox"/>	_____

Eyes feel tired	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nausea associate with visual tasks	<input type="checkbox"/>	<input type="checkbox"/>	_____

	<u>Yes</u>	<u>No</u>	<u>If yes, when and how often?</u>
Halos around lights	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision at distance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision at near	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tilt head during desk work	<input type="checkbox"/>	<input type="checkbox"/>	_____
Squinting, covering or closing one eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Postural changes when doing desk work	<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"/>	_____
Loss of interest or short attention span for close work	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty sustaining reading / writing	<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"/>	_____
Skip lines when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Repetition of letter or words when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Omission of words when reading / copying	<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"/>	_____
Falling asleep when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Silent vocalization/moving lips while reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Motion / car sickness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty with reading comprehension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Comprehension decreases over time	<input type="checkbox"/>	<input type="checkbox"/>	_____
Letters or words appear to move or float around when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty aligning columns of numbers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Can respond better orally than in writing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Write or print poorly	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor time management	<input type="checkbox"/>	<input type="checkbox"/>	_____
Inconsistent performance in work or sports	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor general coordination / clumsiness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor fine motor coordination	<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: _____

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 spend in front of a computer screen each day? _____

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

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

Your eyes to your source documents? _____

Where is the top of your screen located?

- At eye level
- Above eye level
- Below eye level

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
- Flat (horizontal) or vertical

Do you wear glasses, contact lenses, or other optical devices 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: _____

EMPLOYMENT OR SCHOOL:

How many hours a day do you spend at your desk? _____

Are your eyes fatigued at the end of the day? Yes No

Do you feel you are working up to your potential at work or in 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: _____

HOBBIES/SPORTS

Please list the activities that comprise of your leisure time: _____

How many days per week? _____

Do you participate in athletic sports? Yes No

If yes, what type? _____

Do you feel you are reaching your potential in sports/athletics? Yes No

Of all the sports you have played:

List the ones you excel in: _____

List the ones you avoid or can be improved through vision enhancement: _____

Payment Policy/HIPAA

Examination and procedure fees are due at the time of service and may be submitted to your major medical insurance carrier. Any applicable co-payments are due at the time of service. If you have insurance coverage for these services for these services or materials, we will submit claims for you. However, we are not liable for collecting your claim. After 30 days, we will expect payment in full if your insurance company has not paid. Returned NSF checks will be charged a service fee of \$35.00.

- I HEREBY AUTHORIZE MY INSURANCE CARRIER TO MAKE PAYMENT DIRECTLY TO CLARENDON VISION DEVELOPMENT CENTER FOR ANY AND ALL SERVICES RENDERED TO ME BY CLARENDON VISION DEVELOPMENT CENTER. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.
- I HAVE READ AND AGREE TO THE PAYMENT POLICY STATED ABOVE.
- I HAVE RECEIVED HIPAA POLICY STATEMENT AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

Signature _____ **Date** _____

RELEASE OF INFORMATION AND INSURANCE FILING

IT IS OFTEN BENEFICIAL TO EXCHANGE INFORMATION AND DISCUSS YOUR RESULTS WITH OTHER PROFESSIONALS INVOLVED IN YOUR CARE. PLEASE SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION.

I give my consent to make copies of my record and share any pertinent data from this exam to the other professionals. I also give my consent to provide any information to the health care providers or insurance carriers upon their written request for processing my claims. This authorization shall be considered valid throughout the duration of treatment.

Signature

Date

RELATIONSHIP TO PATIENT

Thank you for carefully completing this questionnaire. The information you supplied will allow for a more comprehensive evaluation and better meet your specific visual needs.

If you have any questions, please contact our office at (630) 323-7300 prior to your appointment. We request a minimum of 24 hours notice if you are unable to keep this appointment.

Please be on time for your examination, so that we will have the maximum opportunity to evaluate your visual status.