PATIENT HISTORY FORM

Please fill out this questionnaire carefully and bring it to our office for your scheduled appointment.

GENERAL INFORMATION

Patient Name____ Date of Birth_____________________________
Referred By____

Present Situation
What prompted you to schedule this evaluation?____
____
____
List any current vision problems/concerns:____
____
____
At what age did this problem begin?____
____
Has the problem become better or worse?____________________Explain_____________________________________
____
Does any one else in your family have a similar problem?____
____
Has there been previous treatment?____
____
During sports or physical activity, do you experience:

__ Difficulty throwing/catching a ball
__ Missing hitting the ball
__ Awkwardness or clumsiness
__ Difficulty following a moving target
__ Poor depth perception
__ Action happening too fast
__ Losing your orientation
__ Motion sickness

What would you like to achieve? Please list some specific goals:
____
____

Have you noticed any of the following symptoms while reading, working on the computer or doing paperwork? Please mark symptoms which occur frequently with two checks and those which occur occasionally with one check.

SYMPTOMS

__ Losing place
__ Skipping lines
__ Using finger as a pointer
__ Loss of comprehension
__ Excessive movement/squirming/hyperactivity
__ Misaligning numbers or digits in a column
__ Changing beginnings or ending of words
__ Skipping or missing small words
__ Re-reads lines unknowingly
__ Squinting or frowning
__ Closing or covering one eye
__ Excessive head tilt
__ Trouble copying from chalkboard to paper
__ Trouble copying from book to notebook
__ Slow, laborious reading
__ Avoidance of close work
__ Short attention span
__ Must re-read to obtain meaning
__ Distance blur after reading or paperwork
__ Blurring of print
__ Doubling of print
__ Print moving around
__ Reversals
__ Watery eyes
__ Eyestrain
__ Eye fatigue
__ Burning of eyes
__ Headaches
__ Nausea
__ Dizziness
__ Excessive blinking
__ Rubbing eyes
__ General discomfort
__ Tired eyes
__ Bloodshot eyes
__ Sleepiness
__ Frustration
__ Fatigue easily

MEDICAL HISTORY

List illness, bad falls, high fever, etc.:

Illness/Injury Age Mild/Severe Complications (if any)

____
____
____
____

List any medication or over-the-counter drugs taken at the present time: (name of medication and reason)

____
____
____

Health at present: Excellent________Good_______Fair_______Poor_______

Are there any chronic problems like asthma, hay fever, cold, allergies, or ear infections? (circle any that apply)

When was your last vision examination?________________________________Dr.________________________________

Were glasses prescribed?_________Were recommendations made?___________________If yes, explain: __________
____

Was the treatment program followed?____

Was the treatment effective?____

Has a program of vision therapy been recommended?___________Completed?_________________________________

Is there a history of hearing or speech related problems?__________Explain:

____
____
____

Have you been diagnosed with: ☐ ADD/ADHD ☐ Dyslexia ☐ Learning Disability

If not, do you feel like you have a learning disability? Yes________No_________

Has a neurological, psychological, educational, visual, speech or hearing evaluation been performed?

Type of Evaluation By Whom Diagnosis

____
____
____
____

Is there anything else you want to share that you feel is important?____

____
____
____
____
____