ADULT BINOCULAR VISION CLINIC HISTORY FORM

Please fill out this form carefully.
Please return it to our office prior to your appointment in the envelope provided. Thank you.

Patient's Name: _____ Birthday: _____ /_____ /_____ Age: _____

Occupation: _____ Male ☐ Female ☐ Email: _____

Mailing Address: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Eye Doctor: _____ Phone: _____

Were you referred to our clinic? Yes ☐ No ☐

If yes, whom may we thank for this referral? _____ Relationship to referral source: _____

Mailing Address: _____ Phone: _____

Please state the major reason you would like to be examined: _____

_____

VISION (Please place a check in the appropriate box)

	Never (0)	Rarely (1)	Occasionally (2)	Frequently (3)	Always (4)
Do your eyes feel tired when reading or doing close work?					
Do your eyes feel uncomfortable when reading or doing close work?					
Do you have headaches when reading or doing close work?					
Do you feel sleepy when reading or doing close work?					
Do you lose concentration when reading or doing close work?					
Do you have trouble remembering what you have read?					
Do you have double vision when reading or doing close work?					
Do you see the words move, jump, swim, or appear to float on the page when reading or doing close work?					
Do you feel like you read slowly?					
Do your eyes ever hurt when reading or doing close work?					
Do your eyes ever feel sore when reading or doing close work?					
Do you feel a "pulling" feeling around your eyes when reading or doing close work?					
Do you notice the words blurring or coming in and out of focus when reading or doing close work?					
Do you lose your place while reading or doing close work?					
Do you have to re-read the same line of words when reading?					
Do you experience blurred distance vision?					
Do you have double vision at distance?					
Do you have an eye turn? (crossed or wall-eyed)					
Do you cover one eye when reading or doing close work?					
Do you hold reading material closer than normal?					
Do you have difficulty working at a computer?					
Do you have eye pain?					
Do you have a head tilt?					
Do you have difficulty looking sideways?					
Do you have motion sickness / car sickness?					
Do you have difficulty driving?					
Do you have difficulty judging distances?					
Do you have difficulty hitting / judging moving targets during sports?					

SYMPTOMS AND DIAGOSTIC EXAMS/EVALUATIONS:

Persistent Symptoms:	**Yes**	**No**		**Yes**	**No**	**Date**
Headaches			Last Physical Exam			
Dizziness/lightheadedness			Last Eye Exam			
Seizures			Neurological Exam			
Clumsiness, dropping things, weak grasp			Neuro-Ophthalmological Exam			
Difficulty hearing			Psychological Evaluation			
Ringing of ears			MRI			
Changes in taste			CT Scan			
Changes in smell			Skull X-ray			
Sensitivity to noise/smell/light			EEG			
Numbness/tingling			Visual Field Test			
Difficulty walking			OCT (Optical Coherence Tomography)			
Loss of balance			Other:			

GENERAL HEALTH (PERSONAL & FAMILY):

	Patient	**Family**	**Who in family**		**Yes**	**No**
Diabetes				Head Trauma		
Heart Disease				Concussion		
High Blood Pressure				Loss of Consciousness		
Stroke				Automobile Accident		
Cancer				Seizures		
Thyroid Condition				High Fevers		
Brain Tumor				Asthma		
Multiple Sclerosis				Pregnancy/Birth Complications		
Myasthenia Gravis				Severe Childhood Illness		
Migraines				Physical Impairment		
Seizures				Hearing Impairment		
Neurological/Psychological Disorders				Allergies to foods or medications* Please list below		
Other:				Medications* Please list below		

***Allergies:**_____

***Current medications, including vitamins and supplements:**_____

_____

EYE CARE / HEALTH (PERSONAL & FAMILY):

	Patient	**Family**	**Who in family**
Wear glasses			
Wear contact lenses			
Eye turn / Strabismus			
Lazy eye / Amblyopia			
Blindness			
Eye shaking / Nystagmus			
Glaucoma			
Cataracts			
Eye Disease			
Eye Infection			
Eye Surgery*			
Other visual problems:			

***If you have had eye surgery, please describe what type of surgery, age surgery was performed, number of operations performed, which eye was operated on, and results:*:**_____

_____

PREVIOUS & CURRENT REHABILITATION/THERAPY:

Rehabilitation therapy:	Yes	No	Type of therapy, duration and results
Physical Therapy			
Occupational Therapy			
Speech and Language Therapy			
Vision Therapy			
Eye Patching			
Other Therapy			

BEHAVIOR

(Please respond to the following questions if you have been diagnosed with a head trauma, stroke, or learning disability)

Behavior	Never	Rarely	Occasionally	Frequently	Always
Hyperactive					
Easily distracted					
Short attention span					
Easily frustrated					
Impulsive					
Easily fatigued					
Poor ability to organize work					
Indistinct speech					
Awkward or clumsy					
Behavior problems					
Emotional problems					
Confusion following a series of verbal instructions					
Variable performance (from hour to hour/ day to day)					

EDUCATION AND COGNITION

(Please respond to the following questions if you have been diagnosed with a head trauma, stroke, or learning disability)

School performance as a child	Yes	No	Present cognitive challenges as an adult	Yes	No
Did you have difficulties in school?			Difficulty with short term memory		
Did your grades accurately reflect your true potential?			Difficulty with long term memory		
Did you have trouble completing written assignments?			Difficulty understanding what is said to you		
Did you misread known words?			Difficulty expressing your thoughts in writing		
Did you lose your place while reading?			Difficulty with losing your place when reading		
Did you have difficulties with reading comprehension?			Difficulty with reading comprehension		
Were you diagnosed with a learning disability?			Difficulty with arithmetic or balancing checkbook		

Do you feel your vision limits or prevents you from performing your daily activities in any way? Yes ☐ No ☐

If yes, explain: _____

What specific type(s) of activities do you wish to resume? _____

Signature: _____ Date: _____

If someone else other than the patient is filling out this form:

Name of individual filling out this form: _____ Relationship to patient: _____