

## ADULT VISION QUESTIONNAIRE - EXTENDED

**Please fill out this questionnaire carefully. Please return it to our office prior to your appointment in the envelope provided. **THANK YOU.****

Appointment: Day \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
 Patient's Name: \_\_\_\_\_

### GENERAL INFORMATION

Full Name: \_\_\_\_\_ Male  Female

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_

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

Marital status: Single  Married  Divorced  Widowed

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 Address: \_\_\_\_\_

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

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

Business Address: \_\_\_\_\_

Please list your spouse and dependents:

NAME

Spouse \_\_\_\_\_ Birth Date \_\_\_\_\_

Dependent \_\_\_\_\_ Birth Date \_\_\_\_\_

Dependent \_\_\_\_\_ Birth Date \_\_\_\_\_

Dependent \_\_\_\_\_ Birth Date \_\_\_\_\_

Dependent \_\_\_\_\_ Birth Date \_\_\_\_\_

### MEDICAL HISTORY

Date of most recent evaluation: \_\_\_\_\_ Physician's Name: \_\_\_\_\_

For what problem / condition? \_\_\_\_\_

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: \_\_\_\_\_

Current diet: Excellent  Good  Fair  Poor

Current state of health (explain): \_\_\_\_\_

Is there any history of the following? (please check if there is a history)

	<u>Patient</u>	<u>Family</u>	<u>Who</u>		<u>Patient</u>	<u>Family</u>	<u>Who</u>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Strabismus / crossed eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Amblyopia / lazy eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Brain Tumor	<input type="checkbox"/>	<input type="checkbox"/>	_____

**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? \_\_\_\_\_

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? \_\_\_\_\_

Members of the family who have had visual attention and the reason:

<u>Name</u>	<u>Age</u>	<u>Visual Situation</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**PRESENT SITUATION**

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

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

Do you experience any of the following:

	<u>Yes</u>	<u>No</u>	<u>If yes, when?</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?</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 short-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 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
- Flat (horizontal) or vertical

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 for computer work?

- Glasses
- Contact lenses
- Other (explain): \_\_\_\_\_

**COMPUTERS (continued)**

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

\_\_\_\_\_

**EMPLOYMENT OR SCHOOL**

Current position: \_\_\_\_\_ 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 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: \_\_\_\_\_

RELEASE OF INFORMATION AND INSURANCE FILING

**It is often beneficial to discuss examination results and to exchange information with other co-managing professionals. Please sign below to authorize the release of information.**

I agree to permit information from, or copies of, my examination records to be exchanged with other health care providers or provided to insurance carriers upon their written request or upon the recommendation of the VISION DEVELOPMENT CENTER, P.C., when it is necessary for treatment or for the processing of insurance claims. This authorization shall be valid for the duration of treatment.

\_\_\_\_\_  
Signature or Authorized Representative

\_\_\_\_\_  
Date

WAIVER OF DILATED FUNDUS EXAM

**Services offered at the VISION DEVELOPMENT CENTER, P.C. do not include dilation and evaluation of ocular health. Dilation involves instilling drops in your eyes to enlarge the pupils. This allows your primary care optometrist to see better into the back of the eyes and evaluate the health of the eyes.**

I understand that it is the recommendation of Vision Development Center, P.C. that a dilated fundus exam be performed prior to receiving the services offered therein. I also understand that refusing to have my eyes dilated may result in various ocular diseases to go undetected which may adversely affect my eyes and/or vision.

\_\_\_\_\_  
Signature or Authorized Representative

\_\_\_\_\_  
Date

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation.

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us. We request a minimum of 24 hours notice if you are unable to keep this appointment.

Thank you!



Joan Bauernfiend, O.D.  
Vision Development Center, P.C.