Sports Vision Questionnaire

Please fill out this questionnaire **carefully**. Please bring the completed form with you on the day of the evaluation. Thank you.

Name ____ Age _____ D.O.B. _______________________

Email Address ____

Whom may we thank for referring you to our office? ____

Would you like your report to be faxed, emailed or picked up? __________________________________

Sport___________________________________ # of hours playing sport(s) each day_________________

Team/Club Info__________________________ Coach/Athletic Trainer(s) ___________________________

MEDICAL HISTORY

Date of most recent medical exam__________________ Doctor's name ____________________________

Reason ______________________________________ Results __________________________________

Have you had a sports injury in the last year? No ☐ Yes ☐ If yes, please explain:

____

Have you had a concussion? No ☐ Yes ☐ If yes, how many, when and how:

____

List illnesses, bad falls, high fevers, car accident, etc.________________________________

List any chronic problems (ie. ear infections, asthma, allergies) __________________________________

List any medications currently using (including vitamins and supplements)

____

Is there any history of the following?

	Self	Family		Self	Family		Self	Family
Eye Turn/Strabismus	☐	☐	Lazy Eye/Amblyopia	☐	☐	High Prescription	☐	☐
Colour Blindness	☐	☐	Eye Shake/Nystagmus	☐	☐	Glaucoma	☐	☐
Learning Disabilities	☐	☐	ADD/ADHD	☐	☐	Seizures	☐	☐

VISUAL HISTORY

Date of last eye exam ____________________ Name of previous eye doctor _____________________

Reason for exam ____

Results and recommendations ____

Do you wear glasses for driving, sports, television, computer, reading? (please circle)

Age of first spectacle __________Do you feel glasses or contacts are ideal for your sport? Yes ☐ No ☐

If not, please explain ____

If you wear contacts, what kind? ___________________________ Hours of wearing time? ___________

If you do not wear contacts, are you interested in wearing them? Yes ☐ No ☐

Any eye injuries or eye surgeries? When and describe: ____

____

Do you feel your vision is affecting your sports performance? No ☐ Yes ☐ Describe ___________

____

PRESENT SITUATION

Do you experience any of the following?

1. Intermittent blurry vision at distance /near (please circle) Yes ☐ No ☐
2. Red / Burning eyes Yes ☐ No ☐
3. Itchy / Watery eyes (please circle one) Yes ☐ No ☐
4. Eyes Strain / Tired Yes ☐ No ☐
5. Headaches around forehead, temple or eyes Yes ☐ No ☐
6. Nausea associated with visual tasks Yes ☐ No ☐
7. Starburst or halos around lights Yes ☐ No ☐
8. Double vision at distance / near (please circle) Yes ☐ No ☐
9. Squinting, covering or closing one eye Yes ☐ No ☐
10. Sensitivity to light / lighting / glare (please circle) Yes ☐ No ☐

If yes, when? ____

____

____

SPORTS

What position(s) do you play? ____

What hand do you throw with? R L Both If applicable, which way do you bat/swing R L Switch

Which foot do you kick with? R L Both If applicable, which eye do you sight with? R L

Do you have any visual plan when or before you compete?	Yes ☐	No ☐
Do you do any visual warm up activities?	Yes ☐	No ☐
Do you have any problems with balance?	Yes ☐	No ☐
Is your overall sports performance as consistent as you would like?	Yes ☐	No ☐
Is the level of your performance consistent throughout a game?	Yes ☐	No ☐
Does your performance decrease under pressure?	Yes ☐	No ☐
Does your performance increase under pressure?	Yes ☐	No ☐

Does any of the following interfere with or affect your performance? (Check all that apply):

☐ bright sun	☐ dim light	☐ without sunglasses	☐ with sunglasses
☐ busy background	☐ crowd movement	☐ player movement	☐ crowd noise
☐ rain	☐ uniform colour		

Do you feel you are playing at your potential? Yes ☐ No ☐ If not, please describe: ________________

____

What areas would you like to improve?

☐ Tracking	☐ Visualization	☐ Concentration
☐ Reaction Time	☐ Depth Perception	☐ Attentional Focus
☐ Peripheral Awareness	☐ Judging Distance	☐ Consistency in Performance
☐ Eye-Hand Coordination	☐ Judging Speed	☐ Decreasing Distractibility

If not listed above, list any specific areas you would like to improve in your game:

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(403) 248- 3937