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ADULT VISION QUESTIONNAIRE

If possible, please return this form to our office prior to your appointment.

GENERAL INFORMATION

Full Name: _____ Male ☐ Female ☐

Birth Date: _____ Age: _____ E-mail Address: _____

Home Address: _____

Home Phone: _____ Work Phone: _____

Were you referred to our office? Yes ☐ No ☐

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

Address _____

What is your occupation? _____ Employer: _____

MEDICAL HISTORY

Physician_____Practice_____

Last health evaluation: _____ Current diet: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Please list current medical conditions and medications: _____

_____

_____

Please list vitamins and supplements: _____

Are you allergic to any foods or medications? Yes ☐ No ☐ If yes, please list:

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

☐ **Diabetes**	☐ **Multiple Sclerosis**	☐ **Cancer**	☐ **Heart Disease**
☐ **Depression**	☐ **Anxiety**	☐ **ADHD**	☐ **Genetic Disease**

VISUAL HISTORY Have you had a previous vision examination? Yes ☐ No ☐

If yes, doctor's name: _____ Practice: _____

Reason for examination: _____

Recommendations: _____

Have you had any eye surgeries? _____

_____

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?	Yes	No	If yes, when?
Blurred vision at distance	☐	☐	_____
Blurred vision at near	☐	☐	_____
Red or itchy eyes	☐	☐	_____
Burning eyes	☐	☐	_____
Watery eyes	☐	☐	_____
Eyes hurt	☐	☐	_____
Eyes feel tired	☐	☐	_____
Headaches	☐	☐	_____
Nausea associate with visual tasks	☐	☐	_____
Halos around lights	☐	☐	_____
Double vision at distance	☐	☐	_____
Double vision at near	☐	☐	_____
Tilt head during desk work	☐	☐	_____
Squinting, covering or closing one eye	☐	☐	_____
Postural changes when doing desk work	☐	☐	_____
Need for very bright light when reading	☐	☐	_____
Need for very dim light when reading	☐	☐	_____
Short attention span for close work	☐	☐	_____

	Yes	No	If yes, when?
Difficulty sustaining reading / writing	☐	☐	_____
Visual fatigue at the end of the day	☐	☐	_____
Loss of place when reading	☐	☐	_____
Repetition of letter or words when reading	☐	☐	_____
Omission of words when reading / copying	☐	☐	_____
Use of finger to keep place	☐	☐	_____
Head moves when reading	☐	☐	_____
Confusion of what is being seen or read	☐	☐	_____
Falling asleep when reading	☐	☐	_____
Silent vocalization/moving lips while reading	☐	☐	_____
Motion / car sickness	☐	☐	_____
Comprehension decreases over time	☐	☐	_____
Letters or words appear to move or float	☐	☐	_____
Difficulty aligning columns of numbers	☐	☐	_____
Can respond better orally than in writing	☐	☐	_____
Write or print poorly	☐	☐	_____
Inconsistent performance in work or sports	☐	☐	_____
Poor coordination	☐	☐	_____
Difficulties with short-term memory	☐	☐	_____

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): _____

Where is the top of the computer screen located?

☐ Above your straight-ahead eye level ☐ at eye level ☐ below eye level

Where is the computer screen located? Distance between your eyes and the screen: _____

☐ Directly in front of you when seated ☐ to your right ☐ to your left

Where are your source documents located? Distance away from your eyes: _____

☐ Directly in front of you when seated ☐ to your right ☐ to your left

☐ Flat (horizontal) or ☐ vertical

Do you use any lenses for computer work? Yes ☐ No ☐

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 ☐

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: _____

_____

_____

Are you seriously involved with athletics? Yes ☐ No ☐

List the ones in which you excel: _____

List the ones in which you do poorly/avoid: _____

Do you feel you are achieving up to your potential in sports/athletics? Yes ☐ No ☐

Other Comments: