



ADULT VISION QUESTIONNAIRE - EXTENDED

Please fill out this questionnaire carefully and completely. This form needs to be returned to our office at your scheduled appointment time.

Date: _____

GENERAL INFORMATION

Full Name: _____ Male Female
Birth Date: _____ Age: _____
Home Address: _____
City: _____ Postal Code: _____
Home Phone: _____ Work Phone: _____
Alberta Health Care # _____

Were you referred to our office? Yes No
If yes, whom may we thank for this referral? _____ Phone: _____
Address: _____

What specific areas of difficulty does the individual referring feel you may be experiencing?

What specific problems are YOU noticing/observing?

How long has this problem/difficulty been observed? _____

What are you hoping to determine through this evaluation? _____

MEDICAL HISTORY

List illnesses, bad falls, high fevers, chronic ear infections, hospitalizations etc:

Table with 4 columns: Age, Event, Severe / Mild, Complications

Are you generally healthy? Yes No If no, explain: _____

Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes No

If yes, please list: _____

Family Doctor (circle): _____ Date of most recent evaluation: _____

For what problem/condition? _____

Results and recommendations: _____

Current state of health (explain): _____

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: _____

Is there any **family 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"/>	_____
ADD / ADHD	<input type="checkbox"/>	<input type="checkbox"/>	_____	Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____				

If other, please explain: _____

If ADD/ADHD or a Learning Disability was diagnosed, who diagnosed it, how was it diagnosed and when?

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 recommended? Yes No

If yes, what? _____

Do you use them? Yes No

How long have you had them? _____

If used, when? _____

If not used, 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)? _____

If soft lenses, what brand and strength of powers do you wear? _____

If disposable soft lenses, how often do you throw out your contact lenses and put in your new pair? _____

Do you sleep in your contact lenses? Yes No

If yes, how many days do you sleep in your contact lenses? _____

What contact lens 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

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 Styes	<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"/>	_____

	<u>Yes</u>	<u>No</u>	<u>If yes, when?</u>
Nausea associate with visual tasks	<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 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 when 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 or additional items: _____

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
- Research
- Other (explain): _____

How many hours do you spend 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): _____

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 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? _____

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: _____

IS THERE ANY OTHER INFORMATION THAT YOU FEEL WOULD BE HELPFUL/IMPORTANT IN OUR EVALUATION / TREATMENT?

PLEASE READ AND SIGN THE FOLLOWING:

I understand that should you (a family member) cancel the appointment without 48 hours notice, there will be \$75 cancellation or no show fee. _____

RELEASE OF INFORMATION

It is often beneficial for us to discuss examination results and to exchange information with other professionals involved in your care. Please sign the 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 when it is necessary for the treatment of my visual condition. If I was referred by an optometrist, I agree to allow Dr. Neufeld send the referring optometrist a summary of the results of the testing along with recommendations given. This authorization shall be valid for the duration of treatment.

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 and to better meet your specific visual needs.

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us. You may leave a message for us 24 hours a day / 7 days a week. We request a minimum of 48 hours notice if you are unable to keep your appointment.

Please be on time for your examination so that we will have the maximum opportunity to evaluate your visual status. We ask that you find alternate arrangements for looking after any other children (to prevent unnecessary distractions). Please ensure that you have a good night's sleep the night before the appointment and have had something to eat prior to the appointment so hunger will not be a distraction. We are looking forward to meeting you.

For more information on visual training, visit www.calgaryvisiontherapy.com, www.visiontherapy.com

Sincerely,

Brent W. Neufeld, O.D.
Clinical Director
www.calgaryvisiontherapy.com
<https://www.facebook.com/pages/Calgary-Vision-Therapy/335004866603062>