CLARENDON VISION DEVELOPMENT CENTER

Dr. Monika Spokas
Developmental Optometrist

Dr. Linda Weil
Developmental Optometrist

ADULT VISION QUESTIONNAIRE - EXTENDED

Please fill out this questionnaire carefully and bring it with you to your appointment.

THANK YOU.

GENERAL INFORMATION:

Full Name: _____ Male ☐ Female ☐
Birth Date: _____ Age: _____
Home Address: _____
Home Phone: _____ Email Address: _____
Marital status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Reason for visit:_____

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 #: _____
Name of Primary Insurance Holder: _____ Primary Insurance Holder's DOB: _____
Driver's License No: _____ Social Security Number: _____
What is your occupation? _____ Employer: _____
Business Phone: _____

Please list the names and ages of your family members:

NAME

Dependent _____ Age: _____
Dependent _____ Age _____
Dependent _____ Age _____
Dependent _____ Age _____

MEDICAL HISTORY:

Physician's Name:_____ Phone Number:_____
Physician's Address:_____

Please list the medications you are currently using including vitamins and supplements:

1. _____ Condition:_____
2. _____ Condition: _____
3. _____ Condition: _____
4. _____ Condition: _____
5. _____ Condition: _____

Please list any illnesses, bad falls, high fevers or ear infections, etc.:

Age Severe Mild Complications

_____
_____
_____

760 Pasquinelli Drive, Suite 300,
Westmont, IL 60559 USA

Tel: 630-323-7300
Fax: 630-323-7662

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Was there any related trauma, disease, or condition that preceded or accompanied the onset of your eye turn?
Yes ☐ No ☐
If yes, please explain: _____

Has a neurological evaluation been performed? Yes ☐ No ☐
If yes, by whom?_____
Results and Recommendations: _____
_____

Has a psychological evaluation been performed? Yes ☐ No ☐
If yes, by whom _____
Results & Recommendations: _____
_____

Has an occupational therapy evaluation been performed? Yes ☐ No ☐
If yes, by whom? _____
Results & Recommendations: _____
_____

Medical History: Please mark an "X" on conditions that apply.

1. _____ Crossed Eyes.
2. _____ Amblyopic eye (laze eye).
3. _____ Learning Disability.
4. _____ Dyslexia.
5. _____ ADD/ADHD.
6. _____ Asperger's Syndrome/Autism.
7. _____ Epilepsy/Seizure.
8. _____ Diabetes.
9. _____ High Blood Pressure.
10. _____ Glaucoma.
11. _____ Multiple Sclerosis.
12. _____ Thyroid Condition
13. _____ Brain Tumor/Brain Injury
14. _____ Other. If yes, please list:_____
15. _____ Allergies to foods or medications. If yes, please list:_____
    _____
    _____
    _____

Family History: Please mark an "X" on all conditions that apply and list the family member who has the following condition?

16. _____ Crossed Eyes. Family Member:_____
17. _____ Amblyopic (laze eye). Family Member: _____
18. _____ Learning Disability. Family Member: _____
19. _____ Dyslexia. Family Member: _____
20. _____ ADD/ADHD. Family Member: _____
21. _____ Asperger's Syndrome/Autism: Family Member :_____
22. _____ Epilepsy/Seizure. Family Member: _____
23. _____ Chromosomal Imbalance. Family Member: _____
24. _____ Diabetes. Family Member: _____
25. _____ High Blood Pressure. Family Member: _____
26. _____ Glaucoma. Family Member: _____

27. _____ Multiple Sclerosis. Family Member: _____
28. _____ Near-Sighted. Family Member: _____
29. _____ Far-Sighted. Family Member:_____
30. _____ Other. Family Member: _____

OCULAR 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? _____

HAVE YOU EVER NOTICED THE FOLLOWING:

	Yes	No	If yes, when and how often?
Blurred vision at distance	☐	☐	
Blurred vision at near	☐	☐	
Red or itchy eyes	☐	☐	
Burning eyes	☐	☐	
Frequent Sties	☐	☐	
Watery eyes	☐	☐	
Eyes hurt	☐	☐	
Eyes feel tired	☐	☐	
Headaches	☐	☐	
Nausea associate with visual tasks	☐	☐	

	Yes	No	If yes, when and how often?
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	☐	☐	
Loss of interest or short attention span for close work	☐	☐	
Difficulty sustaining reading / writing	☐	☐	
General or visual fatigue at the end of the day	☐	☐	
Loss of place often when reading	☐	☐	
Skip lines when reading	☐	☐	
Repetition of letter or words when reading	☐	☐	

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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	☐	☐	
Difficulty with reading comprehension	☐	☐	
Comprehension decreases over time	☐	☐	
Letters or words appear to move or float around when reading	☐	☐	
Difficulty aligning columns of numbers	☐	☐	
Can respond better orally than in writing	☐	☐	
Write or print poorly	☐	☐	
Poor time management	☐	☐	
Inconsistent performance in work or sports	☐	☐	
Poor general coordination / clumsiness	☐	☐	
Poor fine motor coordination	☐	☐	
Difficulties with sort-term memory	☐	☐	
Difficulties with long-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): _____

How many hours do you spend in front of a computer screen each day? _____

How do your eyes feel after working on the computer? _____

What is the distance from: your eyes to the screen? _____

Your eyes to your source documents? _____

Where is the top of your screen located?

- ☐ At eye level
- ☐ Above eye level
- ☐ Below eye level

Where is the computer screen located?

- ☐ Directly in front of you when seated
- ☐ To your right
- ☐ To your left

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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 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:

How many hours a day do you spend at your desk? _____
Are your eyes fatigued at the end of the day? Yes ☐ No ☐
Do you feel you are working up to your potential at work or in 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: _____

HOBBIES/SPORTS

Please list the activities that comprise of your leisure time: _____

How many days per week? _____
Do you participate in athletic sports? Yes ☐ No ☐
If yes, what type?_____
Do you feel you are reaching your potential in sports/athletics? Yes ☐ No ☐
Of all the sports you have played:
List the ones you excel in: _____
List the ones you avoid or can be improved through vision enhancement:

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Payment Policy/HIPAA

Examination and procedure fees are due at the time of service and may be submitted to your major medical insurance carrier. Any applicable co-payments are due at the time of service. If you have insurance coverage for these services for these services or materials, we will submit claims for you. However, we are not liable for collecting your claim. After 30 days, we will expect payment in full if your insurance company has not paid. Any balance 90 days after the date of service will incur a monthly billing service charge of $2.00 or 1.3% (15.6% APR) whichever is greater until the balance is paid in full. Returned NSF checks will be charged a service fee of $35.00.

- I HEREBY AUTHORIZE MY INSURANCE CARRIER TO MAKE PAYMENT DIRECTLY TO CLARENDON VISION DEVELOPMENT CENTER FOR ANY AND ALL SERVICES RENDERED TO ME BY CLARENDON VISION DEVELOPMENT CENTER. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.
- I HAVE READ AND AGREE TO THE PAYMENT POLICY STATED ABOVE.
- I HAVE RECEIVED HIPAA POLICY STATEMENT AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

Signature _____ **Date** _____

RELEASE OF INFORMATION AND INSURANCE FILING

IT IS OFTEN BENEFICIAL TO EXCHANGE INFORMATION AND DISCUSS YOUR RESULTS WITH OTHER PROFESSIONALS INVOLVED IN YOUR CARE. PLEASE SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION.

I give my consent to make copies of my record and share any pertinent data from this exam to the other professionals. I also give my consent to provide any information to the health care providers or insurance carriers upon their written request for processing my claims. This authorization shall be considered valid throughout the duration of treatment.

_____ _____

Signature Date

_____

RELATIONSHIP TO PATIENT

Thank you for carefully completing this questionnaire. The information you supplied will allow for a more comprehensive evaluation and better meet your specific visual needs.

If you have any questions, please contact our office at (630) 323-7300 prior to your appointment. We request a minimum of 24 hour notice if you are unable to keep this appointment.

Please be on time for your examination, so that we will have the maximum opportunity to evaluate your visual status.

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