CLARENDON VISION DEVELOPMENT CENTER

Dr. Monika Spokas
Developmental Optometrist

Dr. Amber Cumings, FAAO
Developmental/Pediatric/
Neuro-Optometrist

Dr. Delia Malone
Developmental/Neuro-Optometrist

ADULT VISION QUESTIONNAIRE

Full Name: _____ Male ☐ Female ☐
Birth Date: _____ Age: _____
Home Address: _____
Home Phone: _____ Email Address: _____

Reason for visit: _____
Were you referred to our office? Yes ☐ No ☐
If yes, whom may we thank for this referral? _____ Phone: _____
Address: _____ Email Address: _____
If not referred, how did you learn about our office? _____

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: _____

Allergies to foods or medications. If yes, please list:_____

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

Age	Severe	Mild	Complications

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

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HEALTH HISTORY: Check any conditions that apply to your child or that run in your family.

Diabetes	☐ Self	☐ Family	Epilepsy/Seizures	☐ Self	☐ Family
High blood pressure	☐ Self	☐ Family	Color "blind"	☐ Self	☐ Family
High Cholesterol	☐ Self	☐ Family	Nearsighted	☐ Self	☐ Family
Thyroid	☐ Self	☐ Family	Farsighted	☐ Self	☐ Family
Heart problem	☐ Self	☐ Family	Refractive Eye Surgery (Lasik, PRK)	☐ Self	☐ Family
Cancer	☐ Self	☐ Family	Glaucoma	☐ Self	☐ Family
Respiratory Disease	☐ Self	☐ Family	Cataracts	☐ Self	☐ Family
Ear/Nose/Throat Problems	☐ Self	☐ Family	Macular degeneration	☐ Self	☐ Family
Muscle/Bone/Joint Problems	☐ Self	☐ Family	Retinal Detachment	☐ Self	☐ Family
GI Problems	☐ Self	☐ Family	Blindness	☐ Self	☐ Family
Skin Problems	☐ Self	☐ Family	Lazy Eye	☐ Self	☐ Family
Psychiatric Problems	☐ Self	☐ Family	Crossed Eyes	☐ Self	☐ Family
Allergies/Immunologic Problems	☐ Self	☐ Family	ADD/ADHD	☐ Self	☐ Family
Migraines/headaches	☐ Self	☐ Family	Learning Disability	☐ Self	☐ Family
Head Trauma/Concussion	☐ Self	☐ Family	Dyslexia	☐ Self	☐ Family

Other medical conditions:_____

_____

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: _____

_____

Wear 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)? _____

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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	☐	☐	
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	☐	☐	
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 short-term memory	☐	☐	
Difficulties with long-term memory	☐	☐	

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COMPUTERS/SCREEN USAGE:

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/device screen each day? _____
How do your eyes feel after working on the computer or using devices? _____
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

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: _____

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RETINAL IMAGING

We are pleased to provide our patients with an advanced digital retinal exam. It is great for documenting a baseline image for our charts, screen for eye diseases, and improve our ability to view your internal retinal health. A dilated exam may still be recommended by the doctor if a more peripheral view of the retina is indicated. Since insurance only covers retinal photos after eye disease is discovered, the Retinal Imaging Exam is an out-of-pocket expense. The fee is $45.00.

☐ I want to have my retinal health evaluated with Retinal Imaging.

☐ I do not wish to have Retinal Imaging Exam. I understand that I will still have a thorough eye exam with dilation.

Signature _____ Date _____

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