CLARENDON VISION DEVELOPMENT CENTER

Dr. Monika Spokas
Developmental Optometrist

Dr. Marija Novakovich
Developmental/Pediatric/
Neuro-Optometric

Dr. Dana Shannon, FAAO
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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WELLNESS ASSESSMENT

Introducing Our Enhanced Eye Wellness Exam! Experience the next level of eye care with our Eye Wellness Exam, now including a fundus photo. This advanced digital retinal exam offers several benefits for your eye health. Firstly, it allows us to assess the health of your macula, which is vital for clear central vision. Additionally, it helps us screen for common eye diseases such as macular degeneration and glaucoma. The exam establishes a baseline for your eye health history, aiding in the early detection of any vital changes. It's important to note that insurance typically covers retinal photos only when an eye disease is already detected. In certain instances, the doctor might suggest a dilated exam to obtain a more thorough view of your retina, but only if deemed necessary based on the findings of this examination. Your eye health is our priority, and we're committed to providing you with the best care possible. The Retinal Imaging Exam comes at an out-of-pocket cost of **$55.00.**

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

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

Signature _____ Date _____