CLARENDON VISION DEVELOPMENT CENTER

Dr. Monika Spokas
Developmental Optometrist

Dr. Amber Cumings, FAAO
Developmental/Pediatric/
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? _____

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: _____

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: _____

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Has an occupational therapy evaluation been performed? Yes ☐ No ☐

If yes, by whom? _____

Results and recommendations: _____

PATIENT'S MEDICAL HISTORY: Please mark an "X" on conditions that apply.

_____ Strabismus (Crossed Eyes)
_____ Amblyopia (Poor Vision)
_____ Learning Disability
_____ Dyslexia
_____ ADD/ADHD
_____ Asperger's Syndrome/Autism
_____ Epilepsy/Seizure
_____ Chromosomal Imbalance
_____ Diabetes
_____ Thyroid Condition
_____ Brain Tumor/Brain Injury/Concussion
_____ Other, please list:_____

FAMILY MEDICAL HISTORY: Please mark an "X" on all conditions that apply and list the family member(s) who has the following condition?

_____ High Cholesterol - Family Member(s): _____
_____ Thyroid - Family Member(s): _____
_____ Heart Disease - Family Member(s): _____
_____ Cancer - Family Member(s): _____
_____ Diabetes - Family Member(s): _____
_____ High Blood Pressure - Family Member(s): _____
_____ Glaucoma - Family Member(s): _____
_____ Cataracts - Family Member(s): _____
_____ Macular Degeneration – Family Member(s): _____
_____ Retinal Detachment - Family Member(s): _____
_____ Strabismus (Crossed Eyes) - Family Member(s):_____
_____ Amblyopia (Poor Vision) - Family Member(s): _____
_____ Near-Sighted - Family Member(s): _____
_____ Far-Sighted - Family Member(s):_____
_____ Other - Family Member(s): _____

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? _____

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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)? _____

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	☐	☐	

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	Yes	No	If yes, when and how often?
Poor fine motor coordination	☐	☐	_____
Difficulties with sort-term memory	☐	☐	_____
Difficulties with long-term memory	☐	☐	_____

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 $35.00.**

☐ 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 _____

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 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.

THE OFFICE'S COMPLETE HIPAA POLICY STATEMENT IS AVAILABLE FOR REVIEW UPON REQUEST.

- I ACKNOWLEDGE THAT I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW THE OFFICE'S HIPAA POLICY STATEMENT.

Signature of Responsible Party _____ Date _____

APPOINTMENT CANCELLATION / NO SHOW POLICY

Thank you for trusting your medical care to Clarendon Vision Development Center. When you schedule an appointment with Clarendon Vision Development Center, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

- Please provide our office a 24-hour notice if you need to reschedule or cancel your appointment.
- A "No-Show", "No-Call" or missed appointment, without proper 24-hour notification, will be charged a $150 fee. In the event of an emergency where prior notice could not be given, consideration will be given, and a one-time exception may be granted.
- If you are more than 10 minutes late for your appointment, the appointment may be cancelled and rescheduled.
- If a reminder call or message from our office is not received by the patient, the cancellation policy still remains in effect.

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- The cancellation/no show fees are the sole responsibility of the patient and must be paid in prior to the patient's next appointment.
- This fee is not billable to your insurance.

If you have any questions regarding this policy, please let our staff know and we will be glad to answer them.

I have read and understand the Appointment Cancellation/No Show Policy and agree to its terms.

Signature of Responsible Party _____ Date _____

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

If you have any questions, please contact our office at (630) 323-7300 prior to your appointment.

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