CLARENDON VISION DEVELOPMENT CENTER

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

Neuro-Optometric Patient History Form

Today's Date: _____

Name: _____ Date of Birth: _____

Initial Onset of Condition (trauma, stroke, neuro-degenerative disease, etc):

Describe what happened the first time you were diagnosed or began experiencing symptoms:

_____

_____

_____

SYMPTOMS:

Check all that apply (rate the severity from 1-10 in the box next to symptom; 10 being the worst)

Symptom	1-10	Symptom	1-10	Symptom	1-10	Symptom	1-10	Symptom	1-10
Dizziness		Neck Ache		Lightheadedness		Rocking/tilting		Double Vision	
Nausea		Difficulty Walking		Fatigue		Unsteadiness		Spinning	
Anxiety		Light Sensitivity		Brain Fog		Fainting		Hearing Loss	
Headache		Difficulty Reading		Visual Changes		Falling		Other:	

HISTORY OF PRESENT ILLNESS:

When did your problem start (approximately)? _____

Was it associated with a related event (head injury, stressful situation, etc)? Yes No

If yes, please explain: _____

Was the onset of your symptoms: Sudden Gradual Overnight Other

Describe: _____

Are your symptoms: Constant Variable (come and go)

If variable:

The symptoms/spells occur ever (# of): _____hours _____days _____weeks

_____month ____ years.

The spells last: Seconds Minutes Hours Days

Do you have any warning signs that spells are about to happen? Yes No

If yes, please describe: _____

Are you completely free of symptoms between spells? Yes No

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Do your symptoms occur when changing positions? Yes No

If yes, check all that apply:

X	Position	X	Position	X	Position
	Rolling your body to the left		Rolling your body to the right		Sitting in a chair while it spins
	Moving from a lying to sitting position		Looking up with your head back		Drifting when walking down hallway
	Turning head side to side while sitting/standing		Bending over with your head down		Other:

Is there anything that makes your symptoms better? Yes No

If yes, please explain: _____

Is there anything that makes your symptoms worse? Yes No

If yes, check all that apply:

X	Activity/Situation	X	Activity/Situation	X	Activity/Situation	X	Activity/Situation
	Moving head		Physical activity or exercise		Standing up		Eating certain foods
	Riding or driving in cars		Large crowds or busy environments		Time of day		Menstrual periods (if applicable)
	Loud sounds		Coughing, blowing the nose, straining		Stress		Scrolling on computer or phone
	Bright lights		Driving on the highway		Looking at screens		Other:

When you have symptoms, do you need to support yourself to stand or walk? Yes No

If yes, how do you support yourself? _____

Have you ever fallen because of your current symptoms? Yes No

EAR-RELATED SYMPTOMS:

Do you have difficulty with hearing? Yes No

If yes, which ear(s)? Left Right Both

Do your ear symptoms occur at the same time as your dizziness/imbalance symptoms? Yes No

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DIZZINESS/IMBALANCE SYMPTOMS:

When dizzy or imbalanced, do you experience any of the following?

Symptom	Yes	No
Lightheadedness or a floating sensation?		
Objects or your environment turning around you?		
A sensation that you are turning or spinning while the environment remains stable?		
Nausea or vomiting?		

When you are walking, do you: veer left? veer right? remain in a straight path?

Do you have a head tilt? Yes No

If yes, does it tilt to the: Right Left

Prior medical evaluations, diagnostic testing, and treatment:

Have you seen other healthcare providers for your current condition? Yes No

If yes, who? _____

_____

Have you had any imaging done for your condition (MRI, CT, etc)? Yes No

If yes, please list type: _____

Have you done any rehabilitation/therapy for your condition? Yes No

If yes, please list type: _____

Social History/Lifestyle:

Are you currently employed? Yes No

If yes, what is your occupation? _____

Do you use a computer at work or at home? Yes No

If yes, how many hours a day do you spend on the computer? _____

Do your symptoms get worse on a computer? Yes No

Additional Information:

Please list any additional information you would like to tell the doctor:

_____

_____

_____

_____

_____

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