



**Dr. Monika Spokas**Developmental Optometrist

**Dr. Marija Novakovich** Developmental/Pediatric/ Neuro-Optometric

**Dr. Dana Shannon, FAAO** Optometrist

## Neuro-Optometric Patient History Form

Nausea Difficulty Walking Fatigue Unsteadiness Spinning					ne:	Nam		ə:	Today's Date
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  Dizziness Neck Ache Lightheadedness Rocking/tilting Double V  Nausea Difficulty Walking Fatigue Unsteadiness Spinning  Anxiety Light Sensitivity Brain Fog Fainting Hearing L  Headache Difficulty Reading Visual Changes Falling Other:  HISTORY OF PRESENT ILLNESS:  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 Gradually Overnight Other  Describe:				e, etc):	-degenerative diseas	, neuro	dition (trauma, stroke	of Cond	Initial Onset
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Headache Difficulty Reading Visual Changes Falling Other:  HISTORY OF PRESENT ILLNESS:  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 Gradually Overnight Other  Describe:	nning		Unsteadiness		Fatigue		Difficulty Walking		Nausea
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Describe:							, please explain:	If yes,	
			1161						vvas trie oris
Are your symptoms: Constant Variable (come and go)					·		nbe	Desci	
Are your symptoms. Constant variable (come and go)					and go)	lcome	e: Constant - Variable	antome	Are vour eve
If variable:					aria go,	(001110			Alo your sym
The symptoms/spells occur every (# of):hoursdaysweeks		weeks	s davs	hours	ccur every (# of):	spells o		n vanc	
month years.			•				The dymptomor		
The spells last: Seconds Minutes Hours Days	;		Hours	S	s Minute	Seconds	The spells last:		
Do you have any warning signs that spells are about to happen? Yes No		s No	t to happen? Yes	re about	ng signs that spells a	y warnir	Do you have an		
If yes, please describe:	<u></u>					escribe:	If yes, please de		
Are you completely free of symptoms between spells? Yes No	No	3	lls? Yes	een spe	of symptoms betw	tely free	Are you comple		





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Do your symptoms occur when changing positions?	Yes	No
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If yes, check all that apply:

X	Position	X	Position	Х	Position
	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
	Looking at the ground while walking		Other:	•	

Is there anything that makes your symptoms but If yes, please explain:	petter? Yes	No	
Is there anything that makes your symptoms volume of the second of the symptoms of the symptom	worse? Yes	No	
When you have symptoms, do you need to su If yes, how do you support yourself? _			No
Do you have a head tilt? Yes No If yes, does it tilt to the: Right	Left		
When you are walking, do you: veer left?	veer right?	remain in a straight pa	th?





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No

## Prior medical evaluations, diagnostic testing, and treatment: Have you seen other healthcare providers for your current condition? Yes

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