CLARENDON VISION DEVELOPMENT CENTER

Dr. Monika Spokas
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Neuro-Optometric Patient History Form

Today's Date: _____Name: _____

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

Describe what happened the first time you were diagnosed or began experiencing symptoms, along with approximately when you started having these 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:

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: _____

Are your symptoms: Constant Variable (come and go)

If variable:

The symptoms/spells occur every (# 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
	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 better? Yes No

If yes, please explain:

_____

_____

_____

Is there anything that makes your symptoms worse? Yes No

If yes, please explain:

_____

_____

_____

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

If yes, how do you support yourself? _____

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 path?

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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