Acquired Brain Injury History

Please bring this form to your appointment. If you have ever had any other testing which Dr. Andrich should be aware of, please provide a copy.

The VISION Development Team

andricheye@yahoo.com
www.optometrists.org/andrich

General Information

Patient's full name_____
If married, name of spouse_____

Medical History

Date of injury_____
Explanation of injury_____
_____
_____
_____
Date of most recent medical exam_____
Name of physician_____
Date of last vision examination_____
Name of doctor_____
Results_____
Medications currently using_____
_____
For what condition_____

Please check any of the following professionals that you have seen related to your injury:

☐ Physiatrist ☐ Psychiatrist ☐ Family Physician
☐ Neurologist ☐ Osteopath ☐ Speech Therapist
☐ Psychologist ☐ Chiropractor ☐ Physical Therapist
☐ Massage Therapist ☐ Neuropsychologist
☐ Ophthalmologist ☐ Emergency Room Doctor
☐ Audiologist/Otolaryngologist ☐ Occupational Therapist
☐ Other_____

Names of above physicians/therapists:
1)_____
2)_____
3)_____
4)_____
5)_____

Any history of the following? (please check)

	You	Family
High blood pressure:	☐	☐
Strabismus:	☐	☐
Diabetes:	☐	☐
Thyroid Condition:	☐	☐
Blindness:	☐	☐
Multiple Sclerosis:	☐	☐
Brain Injury:	☐	☐
Stroke:	☐	☐
Amblyopia:	☐	☐
Brain Tumor:	☐	☐
Cataracts:	☐	☐
Glaucoma:	☐	☐

Do you experience the following? (please check)

	Yes	No
Brightness bothers you	☐	☐
Difficulty in stores or malls	☐	☐
Motion sickness	☐	☐
Head turns as reading across page	☐	☐
Eye ache	☐	☐
Losing place often when reading	☐	☐
Headaches	☐	☐
Using finger to keep place	☐	☐
Blurred vision	☐	☐
Short attention span for close work	☐	☐
Eye redness	☐	☐
Skipping words frequently when reading	☐	☐
Double Vision	☐	☐
Orient drawing poorly on page	☐	☐
One eye turns in or out	☐	☐
Squinting covering or closing one eye	☐	☐

	Yes	No
Burning eyes	☐	☐
Tilting head during desk work	☐	☐
Eye drainage	☐	☐
Fatigues easily	☐	☐
Itching eyes	☐	☐
Holding books too closely	☐	☐
Delayed dressing skills	☐	☐
Avoid near tasks	☐	☐
Dislike heights	☐	☐
Difficulty following series of directions	☐	☐
Awkward, poor balance	☐	☐
Difficulty using both sides of body together	☐	☐
Patterned wallpapers/carpet bothersome	☐	☐
Movement of objects in the environment are bothersome	☐	☐

Motor Vehicle Accident

Type of vehicle you were in_____

Other vehicle(s) involved_____

Were you sitting in:

☐ Front Seat ☐ Back Seat ☐ Middle

☐ Left Side ☐ Right Side ☐ Unusual Position

Which restraints were used? (Check all that apply)

☐ Lap ☐ Shoulder ☐ Car Seat

☐ Booster Seat ☐ Air Bag

Speed of vehicle you were in_____

Speed of other vehicle or object_____

Did your vehicle hit another object? ☐ Yes ☐ No

Or did the other vehicle hit your vehicle? ☐ Yes ☐ No

If yes, where was your vehicle hit?

☐ Head on ☐ Toward Front ☐ Drivers side

☐ Rear ended ☐ Toward rear ☐ Passenger side

Did you experience whiplash? ☐ Yes ☐ No

Did you hit your head? ☐ Yes ☐ No

If yes, on what_____

_____

_____

I authorize the release of any medical information to process my insurance claim or the referral to another doctor, school or clinic.

Signed_____

Date_____