The VISION Development Team

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

Adult Sensorimotor 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.

General Information

Patient's full name_____
If married, name of spouse_____

Visual Health History

Reason for today's visit_____
_____
_____
Date of last vision examination_____
Results_____
Previously Diagnosed Visual Conditions_____
_____
Previous Treatments for Visual Conditions_____
_____
_____
Are you currently taking any eye drops?_____
Do you wear glasses?

☐ Yes ☐ No
☐ Constantly ☐ Occasionally
☐ Near ☐ Far

If you have more than one pair of glasses, please describe how/ when you use them. _____
_____

Do you wear contact lenses?

☐ Yes ☐ No
☐ Full time wear ☐ Occasional wear

Please describe your main visually demanding activities and any difficulties you encounter in doing them.

Visual demands (reading, computer, etc.)
At work_____
_____
_____
At play (sports hobbies)_____
_____
_____
_____

Any history of the following? (please check)

	You	Family
High blood pressure:	☐	☐
Eye turn/Strabismus:	☐	☐
Diabetes:	☐	☐
Premature birth:	☐	☐
Retinal disease:	☐	☐
Headaches/migraines:	☐	☐
Sinus problems:	☐	☐
Lazy Eye/Amblyopia:	☐	☐
Allergies:	☐	☐
Color deficiency:	☐	☐
Glaucoma:	☐	☐

Medical History

Most recent medical examination:
Doctor's name_____
Date_____
Results_____
_____
Medication currently taking_____
_____
For what condition_____
_____

Have you been diagnosed as having :

☐ Learning disabilities ☐ Developmental delays
☐ ADD or ADHD ☐ Cerebral Palsy
☐ Seizure Disorders ☐ Autism
☐ Other problems_____

List illnesses, bad falls, head injuries, high fever, ear infections, etc. (include complications and ages)

_____
_____
_____
_____
_____
_____

Are you generally healthy?_____
Are there any chronic problems like asthma, hay fever, allergies?_____
If so, please list_____
_____
_____
_____

Has a neurological evaluation been performed? ☐ Yes ☐ No
By whom?_____
Results_____
_____
_____

Has a psychological evaluation been performed? ☐ Yes ☐ No
By whom?_____
Results_____
_____

Have you ever received:

Occupational therapy services? ☐ Yes ☐ No
By whom and when?_____
Results_____
_____

Physical therapy services? ☐ Yes ☐ No
By whom?_____
Results_____
_____

Speech therapy services? ☐ Yes ☐ No
By whom?_____
Results_____
_____

Other therapy?_____

Present Situation

Is there any concern that some visual dysfunction may be present?_____
_____
If so what?_____
_____
_____

Is your visual dysfunction interfering with your ability to perform your daily functions either at home or work?_____
_____
_____

Do you experience any of the following:

Headaches ☐ Yes ☐ No
When?_____

Blurred vision ☐ Yes ☐ No
When?_____

Double vision ☐ Yes ☐ No
When?_____

Eyes "hurt or tired" ☐ Yes ☐ No
When?_____

Difficulty reading ☐ Yes ☐ No
Describe _____

Difficulty driving ☐ Yes ☐ No
When? _____

Difficulty coordinating the eyes as a team ☐ Yes ☐ No
When? _____

Poor depth perception/ spatial judgments ☐ Yes ☐ No
Describe_____

Other visual perception problems ☐ Yes ☐ No
Describe_____

Eyes frequently reddened ☐ Yes ☐ No
If so, when?_____

Frequent eye rubbing ☐ Yes ☐ No
If so, when?_____

Frequent blinking ☐ Yes ☐ No
If so, when?_____

Closing or covering one eye ☐ Yes ☐ No
If so, when?_____

Head close to paper when reading or writing: ☐ Yes ☐ No

Tilting head when reading ☐ Yes ☐ No
Tilting head when writing ☐ Yes ☐ No
Reversing letters or words ☐ Yes ☐ No
Skip, reread or omit words ☐ Yes ☐ No
Vocalizing when reading silently ☐ Yes ☐ No
Reading slowly ☐ Yes ☐ No
Using a finger as a marker ☐ Yes ☐ No
Poor reading comprehension ☐ Yes ☐ No
Poor writing or printing ☐ Yes ☐ No
Avoid near tasks ☐ Yes ☐ No

Short attention span ☐ Yes ☐ No

Poor motor coordination ☐ Yes ☐ No

Difficulty catching/hitting a ball ☐ Yes ☐ No

List any other concerns that you have concerning your vision:_____

_____

_____

_____

_____

_____

_____

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

Signed_____

Date_____

Educational/ Occupational History

Level of education received_____

Please check all that apply to you.

Slow learner ☐ Yes ☐ No

Motion sensitive ☐ Yes ☐ No

Poor diet/ nutrition ☐ Yes ☐ No

Crave sweets ☐ Yes ☐ No

Difficult childhood ☐ Yes ☐ No

History of substance abuse ☐ Yes ☐ No

History of trouble with the law ☐ Yes ☐ No

Musical ability ☐ Yes ☐ No

Good rhythm ☐ Yes ☐ No

Light sensitive ☐ Yes ☐ No

Touch sensitive ☐ Yes ☐ No

Enjoy sports ☐ Yes ☐ No

Read for enjoyment ☐ Yes ☐ No

Hands on learner ☐ Yes ☐ No

Goals:

Satisfied with current occupational situation ☐ Yes ☐ No

If no, please give a reason why_____

_____

Satisfied with level of education received ☐ Yes ☐ No

If no, please give a reason why_____

_____