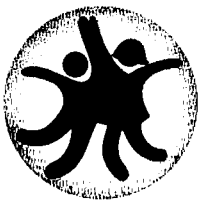

The **VISION** Development Team

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

General Information

Patient's full name_____
If married, name of spouse_____

Sports Participation Information

Primary Sport: _____
Number of years played: _____
What level of sports did you recently participate in prior to injury?

- ☐ Pro-Majors
- ☐ Pro-Minors
- ☐ College
- ☐ High School
- ☐ Recreational Full-time (4-7 per week)
- ☐ Recreational Part-time (1-3 per week)

What activity level would you like to get back to?

- ☐ Professional Athlete
- ☐ Competitive Athlete
- ☐ Scholastic Competitive Athlete
- ☐ Recreational Athlete

Rate your current ability to perform:
(10=no limitation, 1=unable to perform)
Activities of Daily Living _____
Strenuous work (vigorous activities) _____
Sports _____
Sedentary work (sitting activities) _____

Visual Health History

Reason for today's visit_____
_____
_____
Date of last vision examination_____
Results_____
Previously Diagnosed Visual Conditions_____
_____

Sports Vision History

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 ☐ Yes ☐ No

or writing:

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:_____

_____

_____

_____

_____

_____

_____

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_____

_____

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

Signed_____

Date_____