Superior Eye

Health & Vision Therapy Center

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Patient's full name_____
Home phone number_____
E-mail _____
Home address _____
City_____ State_____ Zip_____
Social Security Number _____
Age_____ Birthdate _____
Sex: M F Marital Status: S M D W
Occupation_____
Employer _____
Address _____
City_____ State_____ Zip _____
Work phone number _____
If married, name of spouse _____
Primary Health Care Plan _____
_____
Policy number _____
Insured person _____
Insured Social Security Number_____
Insured Date of Birth_____

Visual Health History

Reason for today's visit _____
_____
_____
Date of last vision examination _____
Results_____
Referred by _____
Previously Diagnosed Visual Conditions _____
_____
Previous Treatments for Visual Conditions _____
_____
_____
Are you currently taking any eye drops? _____

Adult Sensorimotor History

Please return this form at least ONE WEEK prior to your appointment in the enclosed envelope. This in depth history assists Dr. Johnson in determining which visual motor and perceptual tests are needed. If you have ever had any other testing which Dr. Johnson should be aware of, please provide a copy.

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 etc.
_____
_____
_____
_____

Complications & 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? _____
By whom? _____
Results: _____
_____
_____

Has a psychological evaluation been performed? _____
By whom? _____
Results: _____
_____

Have you ever received:
Occupational therapy services? _____
By whom and when? _____
Results: _____
_____
_____

Physical therapy services? _____
By whom? _____
Results: _____
_____

Speech therapy services? _____
By whom? _____
Results: _____
_____

Other therapy? _____

Present Situation

Is there any evidence that some visual malfunction may be present? _____
_____
If so what? _____
_____
_____

Is your visual malfunction 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 problem ☐ Yes ☐ No
Describe _____
Eyes frequently reddened
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 complaints 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; I also allow payment from insurance to be sent directly to Superior Eye Health and Vision Therapy Center.

Signed _____ Date _____