EyeCare™ Specialties
Center for Vision Development

2917 Pine Lake Road Suite B | Lincoln, NE 68512
402.420.2020 | eyecarespecialties.com

Extended Adult Vision Questionnaire

Please fill this questionnaire out carefully and completely.

Appointment Date:____________________

Optometrist: ☐ Rachel Smith, O.D., FCOVD ☐ Mikaela Betka, O.D.

General Information

Patient Full Name:____________________

☐ Male ☐ Female Birth Date:__________ Age:__________

Home Address:__________ City:__________ Zip:__________

Home Phone:__________ Cell:__________ Work:__________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

What is your occupation?____________________

Employer:____________________

Were you referred to our office: ☐ Yes ☐ No

If yes, whom may we thank for this referral? Name:____________________

Emergency Contact Name:____________________

Home Phone:__________ Cell:__________ Work:__________

Family Information

Please list the names of your family.

Spouse:____________________

Dependent:____________________

Dependent:____________________

Dependent:____________________

Dependent:____________________

Responsible Party Information

Name of responsible party:____

Relationship to patient: ☐ Self ☐ Spouse

Spouse's Employer:______________________________ Work Phone:________________

Medical History

Primary Physician:___________________________ Date of last evaluation:______________

What prompted the last visit to the doctor?____________________________________

____

Your current state of health (explain): ____

____

Medications currently using, including vitamins and supplements:____________________

____

Are you allergic to any foods or medications? ☐ Yes ☐ No

If yes, please list:____

Is there any history of the following?

Condition	Patient	Family	Relationship
Diabetes	☐ Patient	☐ Family	Relationship__________
High Blood Pressure	☐ Patient	☐ Family	Relationship__________
Multiple Sclerosis	☐ Patient	☐ Family	Relationship__________
Epilepsy	☐ Patient	☐ Family	Relationship__________
Learning Disability	☐ Patient	☐ Family	Relationship__________
Crossed or Wall Eye	☐ Patient	☐ Family	Relationship__________
Amblyopia/Lazy Eye	☐ Patient	☐ Family	Relationship__________
Glaucoma	☐ Patient	☐ Family	Relationship__________
Concussion	☐ Patient		
Other (Please explain below)	☐ Patient	☐ Family	Relationship__________

____

____

Visual History

Have you had a previous examinations? ☐ Yes ☐ No

If yes, Doctor's name?____________________ Date of last visit:__________

Reason for examination:____________________

Were glasses, contact lenses, or other optical devices prescribed or recommended? ☐ Yes ☐ No

If so, what?____________________ Do you use them? ☐ Yes ☐ No

Why do you feel you need a visual evaluation?____________________

____

How long has the problem/difficulty existed?____________________

____

Symptoms

Do you experience any of the following:

Blurred vision at a distance	☐ Yes ☐ No	If yes, when?__________
Blurred vision at near	☐ Yes ☐ No	If yes, when?__________
Red or itchy eyes	☐ Yes ☐ No	If yes, when?__________
Burning or watery eyes	☐ Yes ☐ No	If yes, when?__________
Eyes hurt/ache with near work	☐ Yes ☐ No	If yes, when?__________
Eyes feel tired	☐ Yes ☐ No	If yes, when?__________
Headaches	☐ Yes ☐ No	If yes, when?__________
Nausea associated with visual tasks	☐ Yes ☐ No	If yes, when?__________
Double vision at a distance	☐ Yes ☐ No	If yes, when?__________
Double vision at near	☐ Yes ☐ No	If yes, when?__________
Tilt head during deskwork	☐ Yes ☐ No	If yes, when?__________
Squinting	☐ Yes ☐ No	If yes, when?__________
Covering or closing an eye	☐ Yes ☐ No	If yes, when?__________
Postural changes when doing desk work	☐ Yes ☐ No	If yes, when?__________
Need for very bright light when reading	☐ Yes ☐ No	If yes, when?__________
Need for very dim light when reading	☐ Yes ☐ No	If yes, when?__________

Visual History (continued)

Symptoms

Do you experience any of the following:

Symptom	Response	If yes
Loss of interest/short attention span for close work	☐ Yes ☐ No	If yes, when?____________
Difficulty sustaining reading/writing	☐ Yes ☐ No	If yes, when?____________
General/visual fatigue at the end of the day	☐ Yes ☐ No	If yes, when?____________
Losing place often when reading	☐ Yes ☐ No	If yes, when?____________
Skip lines when reading	☐ Yes ☐ No	If yes, when?____________
Repetition of letter or words when reading	☐ Yes ☐ No	If yes, when?____________
Omission of words when reading/copying	☐ Yes ☐ No	If yes, when?____________
Use of finger to keep place	☐ Yes ☐ No	If yes, when?____________
Head moves when reading	☐ Yes ☐ No	If yes, when?____________
Falling asleep when reading	☐ Yes ☐ No	If yes, when?____________
Silent vocalization/moving lips while reading	☐ Yes ☐ No	If yes, when?____________
Motion/car sickness	☐ Yes ☐ No	If yes, when?____________
Difficulty with reading comprehension	☐ Yes ☐ No	If yes, when?____________
Comprehension decreases over time	☐ Yes ☐ No	If yes, when?____________
Letters or words appear to move or float around when reading	☐ Yes ☐ No	If yes, when?____________
Difficulty aligning columns of numbers	☐ Yes ☐ No	If yes, when?____________
Can respond better orally than in writing	☐ Yes ☐ No	If yes, when?____________
Inconsistent performance in work or sports	☐ Yes ☐ No	If yes, when?____________
Poor general coordination/clumsiness	☐ Yes ☐ No	If yes, when?____________
Poor fine motor coordination/handwriting	☐ Yes ☐ No	If yes, when?____________
Difficulties with short-term memory	☐ Yes ☐ No	If yes, when?____________
Difficulties with long-term memory	☐ Yes ☐ No	If yes, when?____________

Visual Demands

Computers/Electronic Device Use

Do you use a computer or other electronic devices in your work, school, or leisure time activities? ☐ Yes ☐ No

What tasks do you perform?____________________

____

How many hours do you spend looking at a screen or electronic device each day?__________

How do your eyes feel after working at the computer or electronic device?__________

____

Do you wear any visual correction for computer work? ☐ Glasses ☐ Contact lenses ☐ Other

If other, please explain:____________________

Employment or School

Current position (if employed):____________________

Major courses of study (if in school):____________________

How many hours daily do you spend reading or studying?__________

How many hours daily do you spend working at near distances?__________

Do you feel you are achieving your potential in work or school? ☐ Yes ☐ No

Do you feel you are getting adequate return for the amount of effort you put into a task? ☐ Yes ☐ No

If no, please explain:____________________

Describe briefly your daily activities at work or in school:__________

____

Hobbies and Sports

Describe the types of activities that comprise the majority of your leisure time:__________

____

Do you watch TV? ☐ Yes ☐ No If yes, how many hours per day?__________

Are you involved in athletics? ☐ Yes ☐ No

If yes, do you feel you are achieving up to your potential in sports/athletics? ☐ Yes ☐ No

Release of Information

It is often beneficial to us to discuss examination results and to exchange information with other professionals involved in your care. Please sign below to authorize this exchange of information.

I agree to permit information from, or copies of, my examination records to be exchanged with other healthcare providers listed on the back of this release form or upon the recommendation of EyeCare Specialties, P.C. This authorization shall be considered valid throughout the duration of treatment.

Patient Printed Name   Date

Signature of Patient or Authorized Representative

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation of your specific visual needs.

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us at 402-323-2062. You may leave a message for us after the clinic hours and on weekends. We will return your call as soon as possible or the next business day. We request a minimum of 24 hours notice if you are unable to keep this appointment.

Please be on time for your examination, so that we will have the maximum opportunity to evaluate your visual status.

Sincerely,

Rachel M. Smith, OD, FCOVD
Developmental Optometrist

EyeCare Specialties, P.C. is authorized to exchange and/or share information regarding the treatment of my visual condition to the following health care professionals:

Name:______________________________
School or Business:______________________________
Address:______________________________
City:____________________ State:__________ Zip:______________

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Address:______________________________
City:____________________ State:__________ Zip:______________

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School or Business:______________________________
Address:______________________________
City:____________________ State:__________ Zip:______________