VISUAL PROCESSING OPTOMETRY

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PLEASE COMPLETE BOTH SIDES OF THIS FORM FOR ADULT PATIENT

PATIENT'S NAME_____ Preferred Pronouns _____D.O.B._____

Home Address (Street/City/Zip) _____

Home Phone _____ Cell Phone_____

Occupation_____ Gender assigned at birth(if appl)_____

Work Number_____ Social Security #_____-_____-_____

Email (personal or work) _____Vision Insurance Name_____

Vision Insurance Member Name_____ Member ID #_____

SPOUSE'S NAME_____D.O.B._____Last 4 of SS#_____

Home Address (Street/City/Zip)(if different than above_____

Home Phone _____ Cell Phone_____

PERSON RESPONSIBLE FOR THIS ACCOUNT_____SS#_____Relationship_____

Address (if different from above)_____ Phone_____

Emergency Contact_____ Phone Number_____ Relationship_____

WHO REFERRED YOU TO OUR OFFICE?_____

WHAT IS THE REASON FOR THIS EXAMINATION?_____

WHICH OF THE FOLLOWING VISUAL PROBLEMS DO YOU HAVE?

___Blurred distance sight ___Blurred near sight

___Move reading material further away ___Eye strain when working on computer

___Visual problems when driving ___Poor night vision/Haloes ___Glare/light sensitive

___Crossed/turned/"lazy" eye ___Double vision at distance/near ___Cover or close one eye

___Head tilt ___Words/numbers "float" on page ___Motion/car sickness

___Headaches/eye fatigue when reading or doing close work ___Poor depth perception

___Blindness ___Loss of/reduced vision ___Get sleepy reading

___Eyes water ___Dry/sandy or gritty feeling ___Red eyes/itchy/burning

___Cataract ___Flashes/floaters ___Glaucoma

___Macular degeneration ___Eye discharge ___Chronic eye infections

___Styes ___Eye injury/pain

___Other symptoms/problems_____

WHICH OF THE FOLLOWING VISUAL PERFORMANCE PROBLEMS DO YOU HAVE?

___Head movement when reading ___Omission of words when reading or copying ___Skip lines when reading

___Transposing of letters or numbers ___Loss of attention when reading ___Confusion of what is seen

___Difficulty sustaining nearpoint tasks ___Short attention span with visual tasks ___Poor sports performance

___Difficulty aligning columns ___Poor comprehension of reading material ___Achievement below potential

Have you been told that you have: ___ADD ___ADHD ___Dyslexia Other learning disabilities_____

NAME_____FILE #_____DATE_____

Please check any of the following areas in which you or a blood relative has had a problem or condition.

	Self	Family
Allergies		
Hay fever	( )	( )
Medication (indicate reaction)	( )	( )
Cardiovascular		
Heart/Vascular disease	( )	( )
Heart pain	( )	( )
High Cholesterol	( )	( )
Constitutional Symptoms		
Fever	( )	( )
Weight loss/gain	( )	( )
Ears, Nose, Mouth, Throat		
Sinus problems	( )	( )
Chronic cough	( )	( )
Dry throat/mouth	( )	( )
Chronic ear infections	( )	( )
Endocrine		
Diabetes: Type 1 or 2 (circle)	( )	( )
Thyroid problems	( )	( )
Other glands	( )	( )
Gastrointestinal		
Diarrhea	( )	( )
Constipation	( )	( )
Ulcers	( )	( )
Genitourinary		
Genitals	( )	( )
Breasts	( )	( )
Kidneys	( )	( )
Bladder	( )	( )
Prostate	( )	( )
Hematologic/Lymphatic		
Anemia	( )	( )
Bleeding problems	( )	( )

	Self	Family
Immunological		
Autoimmune diseases	( )	( )
Rheumatoid arthritis	( )	( )
Multiple Sclerosis	( )	( )
Other: _____	( )	( )
Skin		
Eczema	( )	( )
Psoriasis	( )	( )
Musculoskeletal		
Arthritis	( )	( )
Muscle pain	( )	( )
Joint pain	( )	( )
Neurological		
Headaches	( )	( )
Migraines	( )	( )
Seizures	( )	( )
Psychiatric		
Nervous disorders	( )	( )
Panic attacks	( )	( )
Depression	( )	( )
Compulsive behavior	( )	( )
Respiratory		
Tuberculosis	( )	( )
Shortness of breath	( )	( )
Emphysema	( )	( )
Asthma	( )	( )
Lung cancer	( )	( )

What is the frequency of use with the following:
Tobacco_____ Alcohol_____
Drugs (marijuana, etc.)_____

Please list any illnesses or medical conditions that were not covered in the above list:_____

_____

Please list any **medications**, **nutritional supplements** or **homeopathics** that you have recently used or are currently using and the dosages:_____

Please list any specific treatments or surgeries you have had:_____

Hobbies:

___Reading ___Sewing ___Computers ___Drawing ___Television ___Cards
___Sports: _____
___Other_____

I authorize the release of reports/examination records (please initial): YES_____ NO_____

_____ ***I understand that I am responsible for ALL charges incurred in the office and that <u>payment is due at the time of service.</u> Billing of insurance companies (except certain restricted VSP programs) is my responsibility.***

_____ ***I understand that I will be charged for any appointments missed or cancelled less than 24 hours in advance.***

Print Name_____Signature_____Date_____