BRIER CREEK VISION CARE
THE CENTER FOR VISUAL LEARNING & REHABILITATIVE THERAPY SUSAN L. DURHAM, O.D., F.C.O.V.D.
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ADULT VISION AND MEDICAL HISTORY QUESTIONNAIRE

Please complete this questionnaire carefully and return it to our office as soon as possible.

GENERAL INFORMATION

Patient's Full Name: _____ Male ☐ Female ☐
Birth Date: _____ Age: _____Occupation: _____
Home Address: _____
Home Phone: _____Cell Phone: _____Work Phone:_____
Were you referred to our office? Yes ☐ No ☐
If yes, whom may we thank for this referral? _____

MEDICAL HISTORY

Physician's Name:_____ Date of Last Evaluation: _____
Current medications and reasons for taking them (including vitamins and supplements): _____
_____
Drug allergies: _____
Do you smoke or use other forms of tobacco? Yes ☐ No ☐
If yes, number of years smoking: _____ Number of packs smoked per day: _____
If no, have you ever been a smoker? Yes ☐ No ☐ If yes, when did you quit? _____
Alcohol use: none ☐ social ☐ 1-2 drinks daily ☐ above average use ☐ alcohol dependence ☐
Narcotic drug use: none ☐ recreational use ☐ chemical dependence ☐

Is there any history of the following?

	Patient	Family	Relation/Details
High blood pressure	☐	☐	_____
Heart disease	☐	☐	_____
High cholesterol	☐	☐	_____
Stroke	☐	☐	_____
Diabetes/Endocrine	☐	☐	_____
Blood/lymphatic	☐	☐	_____
Arthritis	☐	☐	_____
Cancer (type)	☐	☐	_____
Thyroid Disease	☐	NA	_____
Lung Disease (asthma/emphysema)	☐	NA	_____
Ear, nose, throat (allergies)	☐	NA	_____
GI disease (ulcers/acid reflux)	☐	NA	_____
Kidney, Bladder, Genital	☐	NA	_____
Neurological	☐	NA	_____
Acquired/Traumatic Brain Injury	☐	NA	_____
Depression	☐	NA	_____
Anxiety	☐	NA	_____
Infectious disease (HIV/hepatitis)	☐	NA	_____

Surgeries: (list) _____
Female: Are you pregnant? ☐ YES ☐ NO If yes, due date: _____

OCULAR HISTORY	**Patient**	**Family**	**Relation/Details**
Glaucoma	☐	☐	
Cataracts	☐	☐	
Macular degeneration	☐	☐	
Retinal disorders	☐	☐	
Blindness	☐	☐	
Strabismus/eye turn	☐	☐	
Amblyopia/lazy eye	☐	☐	
Eye injuries	☐	NA	
Eye surgeries	☐	NA	

Others: (list) _____

VISUAL HISTORY

Why do you feel you need a vision examination? _____

_____

Have you had a previous vision evaluation? Yes ☐ No ☐

If yes, doctor's name: _____Date of last evaluation: _____

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

If yes: single vision ☐ lined bifocal ☐ no-line bifocal ☐ contact lenses ☐

Are they worn? Yes ☐ No ☐ If yes, when? _____If no, why not? _____

_____

If you wear contact lenses, what type are they? Soft ☐ Rigid ☐ Gas Permeable ☐

If soft, how often do you replace them? daily ☐ 2 weeks ☐ monthly ☐ 3 months ☐ yearly ☐

How long have you worn them? _____

If not worn full time, when do you wear them? _____

How old are your current contact lenses? _____ What solutions do you use? _____

Are there any problems with your current optical prescription? Yes ☐ No ☐

If yes, explain:_____

Were any additional tests, treatments, or therapies recommended? Yes ☐ No ☐

If yes, what? _____

Did you undergo these treatments? Yes ☐ No ☐ Explain: _____

Results and recommendations: _____

Do you experience any of the following:	**Yes**	**No**	**If yes, when?**
Difficulty seeing distance objects	☐	☐	
Difficulty with near vision	☐	☐	
Frequent sties	☐	☐	
Red or bloodshot eyes	☐	☐	
Eyes water	☐	☐	
Eyes itch	☐	☐	
Eyes burn	☐	☐	
Dry eyes	☐	☐	
Bothered by light	☐	☐	

	Yes	No	If yes, when?
Floaters	☐	☐	
Flashes of light	☐	☐	
Fatigue with reading/computer/close work	☐	☐	
Avoid reading	☐	☐	
Letters/words run together/move when reading	☐	☐	
Loss of place when reading	☐	☐	
Need finger to keep place when reading	☐	☐	
Comprehension decreases over time	☐	☐	
Headaches	☐	☐	
Double vision	☐	☐	
Close/cover one eye to see better	☐	☐	
Eye turns in/out/up/down	☐	☐	
Motion sickness / car sickness	☐	☐	

Do you feel your vision hinders your daily activities in any way? Yes ☐ No ☐
If yes, explain: _____

_____

_____

EMPLOYMENT/EDUCATION INFORMATION

What is current employment position? _____

If a student, what is the major course of study? _____

Do you use a computer? Yes ☐ No ☐ How many hours per day? _____

How close are your eyes to the: computer screen: _____reading material:_____

Is there any other information that you feel would be helpful/important in our evaluation and/or treatment? Yes ☐ No ☐

If yes, explain: _____

_____

_____

_____

_____

For Office Use Only O.D. Initial _____Date: _____

Release of Information and Insurance Filing:

It is often beneficial for 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 authorize the release of medical information to other health care providers or insurance carriers upon their written request, or upon the recommendation of ***Brier Creek Vision Care*** when it is necessary for the treatment of my visual condition or for the processing of insurance claims. This authorization shall be considered valid for the duration of my treatment.

_____ _____

Signature of patient or authorized representative Date

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time to better meet your specific visual needs.

If at any time you have any questions or concerns regarding your vision or treatment, please do not hesitate to contact us. You may leave a message for us 24 hours a day/7 days a week.

We request a minimum of 24 hours notice if you are unable to keep this appointment. **Missed appointment fee is $25 without 24 hour advance notice.**

Please be on time for your evaluation so that we may have the maximum opportunity to evaluate your visual status.

Thank you.

The Staff of Brier Creek Vision Care and
The Center for Visual Learning & Rehabilitative Therapy