Virginia Vision Therapy Center
Developmental Optometry - NeuroOptometry - Low Vision Services

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ADULT INFORMATION

Date: _____

CONTACT INFORMATION

Full name: _____

Nickname: _____

Birthdate: ____/____/____ ___ Yrs

Social Security #:_____

Home Address: _____

_____

Home ph# _____

Work ph# _____

Cell ph# _____

Email: _____

Occupation:_____

How Did You Learn About Our Office?

□ Patient referral: who?_____

□ Professional referral: who?_____

□ Internet □ Phone book □ Drs. talk Davis/Carlyle

Is a report of this examination required? Yes No

If yes, please send a copy of report to:

□Referring party □Others:_____

_____

Your Main Concern About Your Vision

_____

_____

_____

_____

_____

_____*Use back of form if needed*

Another family member with similar problem?

_____

Has there been any previous treatment?_____

_____

Date of last eye exam with an eye doctor_____

Name and location of provider:_____

_____

How old are your glasses? _____

Worn for □distance only □reading only □ both

Do you wear contacts? If so, when_____

_____

Please obtain a copy of your glasses' and/or contacts' prescription from your previous eye doctor or optical.

HEALTH HISTORY *Check boxes if yes*:

□ ADD/ADHD	□patient	□family
□ Allergy, chronic	□patient	□family
□ Amblyopia	□patient	□family
□ Autism	□patient	□family
□ Asthma	□patient	□family
□ Blindness	□patient	□family
□ Cancer	□patient	□family
□ Cerebral Palsy	□patient	□family
□ Color blindness	□patient	□family
□ Dairy sensitivity	□patient	□family
□ Developmental delay	□patient	□family
□ Dyslexia	□patient	□family
□ Diabetes	□patient	□family
□ Ear infections	□patient	□family

HEALTH HISTORY Continued *Check boxes if yes:*

□ Eye turns □patient □family
□ Eye surgeries □patient □family
□ Glaucoma □patient □family
□ Gluten sensitivity □patient □family
□ Frequent illnesses □patient □family
□ High fevers □patient □family
□ High blood pressure □patient □family
□ Head/neck injury □patient □family
□ Lactose intolerant □patient □family
□ Lazy eye □patient □family
□ Learning disabilities □patient □family
□ Light sensitive □patient □family
□ Loss of visual field □patient □family
□ Patching of eye □patient □family
□ Respiratory disease □patient □family
□ Seizures □patient □family
□ Sleeping problems □patient □family
□ Strokes □patient □family
□ Other:_____

Medications: _____

_____

VISION HISTORY *Please check if yes:*

Distance *(Driving, Outdoor activities, TV, Movies)*

□ Blur
□ Blurring after detailed, close-up work
□ Eyes itch, burn, red, water (circle)
□ Headaches
□ Double vision
□ Poor depth perception
□ Difficulty parking car in tight spots
□ Frequent fender-benders
□ Nausea in rear of car
□ Discomfort/anxiety in shopping areas
□ Tendency to bump into people/objects
□ Extreme fatigue at end of day

Night Driving Vision

□ Stopped driving at night due to vision
□ Headlight glare bothersome
□ Blur
□ Poor depth perception

Near Vision *(Computer use, reading, deskwork)*

□ Reads very little for enjoyment
□ Loss of place while reading
□ Headaches
□ Neck/shoulder pain
□ Print or computer screen not clear
□ Difficulty remembering what is read

How do you mainly use your eyes?

□Computers □Driving □Working with hands
□Deskwork □Other_____

Low Vision Only:

Do you drive? Yes No
□ Daytime only? □ Both daytime and nighttime?
DMV licensing forms needed at this appt? Yes No
Do you use a mounted telescope for driving? Yes No
If so what type?_____ Power? _____
When did you receive? _____
Are you interested in services from the Virginia Dept for Blind and Visually Impaired? Yes No
Information from this exam sent to: _____

_____

Signed:_____