Vision Therapy Centers, SC
1401 McMahon Dr., Suite 100
Neenah, WI 54956

Dr. Linda Dejmek O.D.,FCOVD
Neuro-Developmental
Optometrist

Office: 920-722-2020
Toll Free: 888-613-2020
Fax: 920-722-2022

email: info@abseevision.com

Please bring this form to your appointment. This assists us in determining the visual performance tests needed.

Adult History

Date_____Completed By_____
How did you learn about A B See?_____

General Information

Patient's name
_____
(LAST) (FIRST) (M)
Birth Date_____Age_____Gender F M
Home Address_____
_____
City_____ State_____ Zip_____
E-mail _____
Home Phone___(____)_____
Cell Phone___(____)_____
Fax number ___(____)_____
What is or was your occupation?_____
Employer_____
Work Address_____
_____
City_____State_____Zip_____
Work Phone___(____)_____
May we contact you at your business ? Yes ☐ No ☐

If married, name of spouse
_____
(Last) (First) (M)

Cell Phone___(____)_____
E-mail_____
Occupation_____
Employer_____
Work Phone___(____)_____

Patient's Insurance Information
Primary Health Care Plan_____
Medical Billing Address_____
_____
Policy Holder_____
Policy Number_____Group #_____

Emergency contact_____
Caregiver_____

Visual History

Previous eye examination:
Date:_____
Doctor's name:_____
Location:_____
Reason for examination:_____
_____
_____

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 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	
☐	☐	Eye turn/Strabismus
☐	☐	Lazy Eye/Amblyopia
☐	☐	Retinal disease
☐	☐	Color deficiency
☐	☐	Glaucoma
☐	☐	Cataracts
☐	☐	Eye Surgery

Medical History

Patient's Name_____Date_____

Please check any of the following which pertains: Last Medical Examination Date_____

Allergies/ Immunology
_____Drug Allergies
_____Environmental Allergy
_____Rheumatoid Arthritis
_____Lupus
_____Other
List all allergies:

Respiratory
_____Allergies
_____Cigarette Smoker
_____Asthma
_____Bronchitis
_____Other
Explain:

Psychiatric
_____Depression
_____Panic Disorder
_____Schizophrenia
_____Memory Loss
_____Other
Explain:

Integumentary
_____Eczema
_____Rosaces
_____Psoriasis
_____Ring Worm
_____Other
Explain:

Cardiovascular
_____Heart Disease
_____Hypertension
_____Stroke
_____Vascular Disease
_____Other
Explain:

Musculoskeletal
_____Fibromyalgia
_____Muscular Dystrophy
_____Osteoarthritis
_____Cold Extremities
_____Other
Explain:

Constitutional
_____General Good Health
_____Recent Weight Change
_____Fever
_____Fatigue
_____Developmental Disability
_____Other
Explain:

Neurological
_____Paralysis
_____Numbness or Tingling
_____Headaches
_____Light Headed or Dizzy
_____Convulsions/Seizures
_____Tremors
_____Head Injuries
_____Other
Explain:

Eye/Ear/Nose
_____Tubes in Ears
_____Earaches or Drainage
_____Chronic Sinus Problems
_____Glaucoma
_____Cataracts
_____Eye Turn
_____Hearing Loss Injury
_____Other
Explain:

Hematological/ Lymphatic
_____Anemia
_____Bleeder
_____Slow to heal after cut
_____Leukemia
_____Large volume blood loss
_____Enlarged glands
_____Blood transfusions
_____Other
Explain:

Gastrointestinal
_____Loss of appetite
_____Bowel movement changes
_____Abdominal pain
_____Crohn's
_____Colitis
_____Ulcers
_____Other
Explain:

Endocrine
_____Non insulin dep. Diabetic
_____Insulin dep. Diabetic
_____Thyroid dysfunction
_____Hormonal dysfunction
_____Other
Explain:

This information is confidential. However, you may discuss this portion directly with the doctor if you prefer.

☐ Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty when driving? ☐ Yes ☐ No
If yes, please describe:_____
Do you use tobacco products? ☐ Yes ☐ No If yes, type/amount/how long?_____
Do you drink alcohol? ☐ Yes ☐ No If yes, type/amount/how long?_____
Do you use illegal drugs? ☐ Yes ☐ No If yes, type/amount/how long?_____
Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Medical History Continued

Most recent medical examination:
Date:
Doctor's name:
Location:
Results:

Medications:	Conditions:

List illnesses, bad falls, head injuries, high fever, surgeries, etc.

Complications and 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?

Have there been any treatments to remedy the problem such as:
Vision therapy
Patching
Eye surgery
Other

Have you seen improvements with therapy?

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 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: Yes ☐ No ☐
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?_____

Yes ☐ No ☐ Head close to paper when reading or writing
Yes ☐ No ☐ Tilting head when reading
Yes ☐ No ☐ Tilting head when writing
Yes ☐ No ☐ Confuses letters or words
Yes ☐ No ☐ Reverses letters or words
Yes ☐ No ☐ Skips, re-reads or omits words
Yes ☐ No ☐ Vocalizes when reading silently
Yes ☐ No ☐ Reads Slowly
Yes ☐ No ☐ Uses finger as a marker
Yes ☐ No ☐ Poor reading comprehension
Yes ☐ No ☐ Writes or prints poorly
Yes ☐ No ☐ Tires easily
Yes ☐ No ☐ Avoids near tasks
Yes ☐ No ☐ Short attention span
Yes ☐ No ☐ Poor motor coordination
Yes ☐ No ☐ Difficulty catching/ hitting a ball

List any other complaints that you have concerning your vision:_____

Educational/Occupational History

Level of education received:_____

Please check all that apply to you:
Yes ☐ No ☐ Slow learner
Yes ☐ No ☐ Motion sensitive
Yes ☐ No ☐ Poor diet/nutrition
Yes ☐ No ☐ Difficult childhood
Yes ☐ No ☐ History of substance abuse
Yes ☐ No ☐ Light sensitive
Yes ☐ No ☐ Touch sensitive
Yes ☐ No ☐ Enjoy sports
Yes ☐ No ☐ Read for enjoyment
Yes ☐ No ☐ Hands on learner

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._____

What do you hope a Visual Rehabilitation Program will do for you?_____

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 A B See Vision Therapy Centers, SC. 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.

_____ 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 and to better meet your specific visual needs.

Patient's Name _____Date_____

COVD-Quality of Life Questionnaire

Check the column which best represents the occurrence of each symptom.

Completed by: _____

	Never	Seldom	Occasional	Frequently	Always
Headaches with near work					
Words run together when reading					
Burning, itchy, watery eyes					
Skips/repeats lines when reading					
Head tilt/closes one eye when reading					
Difficulty copying from the chalkboard					
Avoids near work/reading					
Omits small words when reading					
Writes up/down hill					
Misaligns digits/columns of numbers					
Difficulty comprehending what is read					
Holds document/book too close					
Trouble keeping attention on reading					
Difficulty completing assignments					
Always says "I can't" before trying					
Clumsy, knocks things over					
Does not use his/her time well					
Loses belongings/things					
Forgetful/poor memory					

Other comments: