# ADULT VISION QUESTIONNAIRE

***Please fill out this questionnaire and return it to the clinic prior to your appointment.***

## GENERAL INFORMATION

Patient's Name: ______________________________ Gender: ____________
Birth Date: ____________________ Age: ______
Home Address: ______________________________City/State:____________ Zip: ________
Home Phone: ________________________ Work Phone:__________________________
Cell Phone: _________________________
Email: ____________________________________________________________
Social Security Number: ______________________ Driver's License No.:______________
Marital status: ______________________ Occupation: __________________________
Employer: ________________________________ Business Phone: _______________
Business Address: ____________________________ City/State: __________ Zip: ________
Spouse/Partner's Name: ______________________ Cell Phone: __________________
Spouse/Partner's Occupation: ______________________
Spouse/Partner's Employer: ____________________ Business Phone: _______________
Business Address: ____________________________ City/State: __________ Zip: ________

Whom may we thank for this referral? ______________________________________
Address: ____________________________________ Phone: __________________

## PRESENT SITUATION

Why do you feel the need for a visual evaluation? ______________________________
____________________________________________________________________
How long has this problem/difficulty existed? ___________________________________
Is this problem/difficulty a result of a work-related accident? _______________________

| Do you experience any of the following? | Yes | No | If yes, when? |
|---|---|---|---|
| Blurred vision at distance | ☐ | ☐ | ____________ |
| Blurred vision at near | ☐ | ☐ | ____________ |
| Red or itchy eyes | ☐ | ☐ | ____________ |
| Burning eyes | ☐ | ☐ | ____________ |
| Frequent Sties | ☐ | ☐ | ____________ |
| Watery eyes | ☐ | ☐ | ____________ |
| Eyes hurt | ☐ | ☐ | ____________ |
| Eyes feel tired | ☐ | ☐ | ____________ |
| Headaches | ☐ | ☐ | ____________ |
| Nausea associate with visual tasks | ☐ | ☐ | ____________ |
| Halos around lights | ☐ | ☐ | ____________ |
| Double vision at distance | ☐ | ☐ | ____________ |

| | Yes | No | If yes, when? |
|---|---|---|---|
| Double vision at near | ☐ | ☐ | |
| Tilt head during desk work | ☐ | ☐ | |
| Squinting, covering or closing one eye | ☐ | ☐ | |
| Postural changes when doing desk work | ☐ | ☐ | |
| Need for very bright light when reading | ☐ | ☐ | |
| Need for very dim light when reading | ☐ | ☐ | |
| Loss of interest or short attention span for close work | ☐ | ☐ | |
| Difficulty sustaining reading/writing | ☐ | ☐ | |
| General or visual fatigue at the end of the day | ☐ | ☐ | |
| Loss of place often when reading | ☐ | ☐ | |
| Skip lines when reading | ☐ | ☐ | |
| Repetition of letter or words when reading | ☐ | ☐ | |
| Omission of words when reading/copying | ☐ | ☐ | |
| Use of finger to keep place | ☐ | ☐ | |
| Head moves when reading | ☐ | ☐ | |
| Confusion of what is being seen or read | ☐ | ☐ | |
| Falling asleep when reading | ☐ | ☐ | |
| Silent vocalization/moving lips while reading | ☐ | ☐ | |
| Motion/car sickness | ☐ | ☐ | |
| Difficulty with reading comprehension | ☐ | ☐ | |
| Comprehension decreases over time | ☐ | ☐ | |
| Letters or words appear to move or float around when reading | ☐ | ☐ | |
| Difficulty aligning columns of numbers | ☐ | ☐ | |
| Can respond better orally than in writing | ☐ | ☐ | |
| Write or print poorly | ☐ | ☐ | |
| Poor time management | ☐ | ☐ | |
| Inconsistent performance in work or sports | ☐ | ☐ | |
| Poor general coordination/clumsiness | ☐ | ☐ | |
| Poor fine motor coordination | ☐ | ☐ | |
| Difficulties with short-term memory | ☐ | ☐ | |
| Difficulties with long-term memory | ☐ | ☐ | |

Comments on any items above: ______________________________

______________________________

______________________________

**VISUAL HISTORY**

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

If yes, doctor's name: ______________________________

Date of last visit: ______________

Reason for examination: ______________________________

Results and recommendations: ______________________________

______________________________

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

If so, what? ______________________________

Do you use them? Yes ☐ No ☐

How long have you had them? ______________

If used, when? ______________________________

If not, why not? ______________________________

If you wear contact lenses, how long have you worn them? ______________________________
What type of lenses do you have (i.e. hard, soft, gas-permeable)? ______________________
What contact solutions do you use? ______________________________________________

Members of the family who have had visual problems:

| Name | Age | Visual Situation |
|---|---|---|
| | | |
| | | |
| | | |

**MEDICAL HISTORY**

Date of most recent evaluation: _____________ Physician's Name: ______________________
For what problem/condition? ___________________________________________________
Results and recommendations: __________________________________________________
Medications currently using, including vitamins and supplements: ___________________
______________________________________________________________________
For what condition(s)? ________________________________________________________
Are you allergic to any foods or medications? Yes ☐ No ☐
If yes, please list: ______________________________________________________
Current diet restrictions and/or concerns: ___________________________________________
______________________________________________________________________
Current state of health/any concerns (explain): ______________________________________
______________________________________________________________________
Have you had any head traumas or accidents? Please describe _________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

List illnesses, bad falls, high fevers, ear infections, etc.:

| Age | Severe | Mild | Complications |
|---|---|---|---|
| | | | |
| | | | |

Is there any history of the following? (please check if there is a history)

| | Patient | Family | Who | | Patient | Family | Who |
|---|---|---|---|---|---|---|---|
| Diabetes | ☐ | ☐ | ______ | Strabismus/crossed eye | ☐ | ☐ | ______ |
| Multiple Sclerosis | ☐ | ☐ | ______ | Amblyopia/lazy eye | ☐ | ☐ | ______ |
| Blindness | ☐ | ☐ | ______ | Thyroid condition | ☐ | ☐ | ______ |
| Glaucoma | ☐ | ☐ | ______ | Stroke | ☐ | ☐ | ______ |
| High Blood Pressure | ☐ | ☐ | ______ | Traumatic brain injury | ☐ | ☐ | ______ |
| Cataracts | ☐ | ☐ | ______ | Brain tumor | ☐ | ☐ | ______ |

**COMPUTERS**

Do you use a computer in your work, school, or leisure time activities? Yes ☐ No ☐
If so, indicate the types of computer work you perform:

- ☐ Word processing
- ☐ Programming
- ☐ Data entry
- ☐ Internet

- ☐ Games / Leisure activities
- ☐ Other (explain): ____________________

How many hours do you spend in front of a computer screen each day? ____________

How many hours do you spend using a smart phone/tablet each day? ____________

How do your eyes feel after working at the computer/using smart phone/tablet? ____________

Where is the top of the screen located?

- ☐ Above your straight-ahead eye level
- ☐ At eye level
- ☐ Below eye level

What is the distance from: Your eyes to the screen? ____________

Your eyes to the keyboard? ____________

Your eyes to your source documents? ____________

Where is the computer screen located?

- ☐ Directly in front of you when seated
- ☐ To your right
- ☐ To your left

Where are your source documents located?

- ☐ Directly in front of you when seated
- ☐ To your right
- ☐ To your left
- ☐ Flat (horizontal) or vertical

Do you experience any of the following lighting problems in your work area?

- ☐ Glare from windows or other light sources
- ☐ Reflections on your computer screen
- ☐ Difficulty reading source documents

Do you wear glasses, contact lenses, or other optical devices for computer work?

- ☐ Glasses
- ☐ Contact lenses
- ☐ Other (explain): ____________________

Please describe any additional problems you have with your vision, current glasses or contact lenses for computer work: ____________________

## EMPLOYMENT OR SCHOOL

Current position: ____________ Major course of study: ____________

How many hours daily do you spend at a desk? ____________

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 up to 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: ____________________

Does your work or course of study demand comprehension from the written word? Yes ☐ No ☐

Describe briefly your daily activities at work or in school: ______________________________________
______________________________________________________________________________

**HOBBIES/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? _________________
How many days per week? ______________________
Are you seriously involved with athletics? Yes ☐ No ☐
Do you feel you are achieving up to your potential in sports/athletics? Yes ☐ No ☐
Of all the sports you have played:
List the ones in which you excel: ____________________________________________________
List the ones in which you do poorly/avoid: ___________________________________________

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 related to your specific visual needs. If you would like to communicate via email, please complete and sign the attached Authorization to Email Protected Health Information form. Completed questionnaires can be mailed or faxed to:

NECO Center for Eye Care
930 Commonwealth Ave.
Boston, MA 02215
Fax: 617-396-8517

If you have any questions or concerns that we may answer prior to your appointment, 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.

Please be on time for your examination, so that we will have the maximum opportunity to evaluate your visual status. We are looking forward to meeting you.

Thank you.

Celia Hinrichs, O.D., FCOVD
Gayathri Srinivasan, OD, MS, FAAO