The Visual Learning Center

Adult Symptom/History/Lifestyle Questionnaire

Name:_____ Date of Birth: _____ Gender: _____

Address:_____ City: _____ State: ____ Zip: _____

Best Contact Phone Number: _____ Email: _____

Insurance:
____ Major Medical Company _____

Whom may we thank for referring you to us? _____

Present Situation

Is there any concern that some visual dysfunction may be present? _____
If so, what? _____
_____
Is your visual dysfunction interfering with your ability to perform your daily functions either at home or work? _____
_____

Medical History

List all major health problems to date: _____
_____

List all medications currently being taken: _____
_____

List all allergies: _____

Indicate problem areas:

- ☐ Headaches:
  - Location on head: _____ Onset – time of day: _____
  - How long do they last? _____
  - Type of pain: ☐ sharp ☐ dull ☐ throbbing ☐ other _____
- ☐ Speech or Hearing: If yes, explain _____
_____
- ☐ Head or Eye Injury: If yes, explain _____
_____

Visual History

Date of last vision exam: _____
The patient currently wears: ☐ eyeglasses: date prescribed _____
☐ contact lenses: date prescribed _____

Indicate problem areas:

☐ Blur at far	☐ amblyopia (lazy eye)	☐ headaches/fatigue	☐ eye strain
☐ Blur at near	☐ eye-hand coordination	☐ eye alignment	☐ double vision
☐ astigmatism	☐ depth perception	☐ excessive blinking	☐ color vision

Eye Surgery? If yes, explain _____

Previous Therapy or Evaluations

Has a neurological evaluation ever been performed? ☐ Yes ☐ No
By Whom? _____

Has a psychological evaluation ever been performed? ☐ Yes ☐ No
By Whom? _____

Have you ever received Occupational therapy services? ☐ Yes ☐ No
By Whom? _____

Have you ever received Physical therapy services? ☐ Yes ☐ No
By Whom? _____

Have you ever received Speech therapy services? ☐ Yes ☐ No
By Whom? _____

Have you ever received Vision therapy services? ☐ Yes ☐ No
By Whom? _____

Please check off the appropriate column for each symptom listed:

Visual Complaints:	**Often**	**Sometimes**	**Never**
Do you close or cover one eye?			
Do you feel tired doing ordinary things around the house?			
Do lights bother your eyes?			
Do you feel significant tension when driving?			
Do you have trouble judging distance when walking or parking a car?			

Please check off the appropriate column for each symptom listed:

Reading, Computer and Other Desk Work	**Often**	**Sometimes**	**Never**
Do you get double vision?			
Does your vision get blurry?			
Do you get headaches when reading or on the computer?			
Do your eyes burn or feel strained after short periods of reading or using the computer?			
Do you fatigue quickly when reading?			
Do you experience a lot of tension during close work activities that require concentration?			
Do you skip words or re-read lines?			
Does your reading comprehension decrease over time?			
Do you often lose your place or omit words when reading?			
Do letters or words run together or move when reading?			

How often can you read or work on the computer before your eyes become uncomfortable:

(circle one)

☐ 1-10 minutes ☐ 10-30 minutes ☐ 30 minutes to 1 hour ☐ Longer than 1 hour

Please list all near-activities you participate in (for leisure and work):

_____

_____

_____

_____

_____

Please use this space to list any additional comments you may have: