



INTELLIGENCE

www.holisticvisionsandiego.com
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Dana Dean, O.D

ADULT VISION QUESTIONNAIRE

It is our pleasure to serve you.

Full Name: _____ Male Female
 Birth Date: _____ Age: _____
 Home Address: _____
 Home Phone: _____ Work Phone: _____
 Marital status: Single Married Divorced Widowed
 Were you referred to our office? Yes No
 If yes, whom may we thank for this referral? _____ Phone: _____
 Address _____
 Driver's License No.: _____
 What is your occupation? _____ Employer: _____
 Please list the names and birth dates of your spouse and dependents:

	<u>NAME</u>	<u>Birth Date</u>
Spouse	_____	_____
Dependents	_____	_____
	_____	_____
	_____	_____
	_____	_____

MEDICAL HISTORY

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

	<u>Patient</u>	<u>Family</u>	<u>Who</u>		<u>Patient</u>	<u>Family</u>	<u>Who</u>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Eye Infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Turn	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brain Tumor	<input type="checkbox"/>	<input type="checkbox"/>	_____	Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

Physician's Name: _____ Date of Last Evaluation: _____
 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: Good Fair Poor
 Current state of health (explain): _____

VISUAL HISTORY

Main reason for having an examination today: _____

Date of Last Evaluation: _____ Doctor's name: _____

Reason for examination: _____

Results and recommendations: _____

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

If yes, are they used? Yes No If yes, when? _____

If no, why not? _____

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

If Yes describe: _____

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

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? _____

Do you experience any of the following:	<u>Yes</u>	<u>No</u>	<u>If yes, when?</u>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nausea when doing visual tasks	<input type="checkbox"/>	<input type="checkbox"/>	_____
Motion/car sickness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Halos around lights	<input type="checkbox"/>	<input type="checkbox"/>	_____
Need for bright light	<input type="checkbox"/>	<input type="checkbox"/>	_____
Need for dim light	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes "hurt" or "tired"	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes itch	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes burn	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes tear	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes frequently reddened	<input type="checkbox"/>	<input type="checkbox"/>	_____
Closing or covering one eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lose place while reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
Poor reading comprehension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty maintaining attention when reading	<input type="checkbox"/>	<input type="checkbox"/>	_____
When reading, letters/words appear to move or float around	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do your work or leisure time activities involve any eye hazards? Yes No Explain: _____

If yes, is protective eyewear worn? _____

Do you use a computer? Yes No If yes, how many hours a day? _____

Please enter the following computer working distances:
eyes to the: screen: _____ keyboard: _____ source document: _____

Please describe any problems you have with your current glasses or contact lenses for computer work: _____

Any visual symptoms after using your computer? _____

Does your work/leisure activities require comprehension of the written word? Yes No

If yes, describe: _____

Have you ever had any blows or injuries to your head, eyes, or neck? Yes No

If Yes, describe: _____

Do you feel your vision hinders you in any way? Yes No If yes, How? _____

List any other questions, concerns you may have regarding your vision: _____

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 DANA DEAN OPTOMETRY, THE CENTER FOR VISION DEVELOPMENT 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 and will enable us to perform a more comprehensive evaluation and 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.

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

Thank you.

Sincerely,

Dana Dean, O.D.