Eye Priority, P.C.
Dr. Kelly de Simone, F.C.O.V.D.
15725 South 46th Street ♦ Suite 112 ♦ Phoenix ♦AZ♦ 85048
480-893-2300 ♦ Fax 480-893-0522

ADULT VISION QUESTIONNAIRE

Thank you for carefully completing the questionnaire. Please bring it to our office at your appointment time.

Patient's Name_____DOB_____ Age_____

Who may we thank for referring you to our office? _____

Sex: Male Female Marital Status: Single Married Divorced Widowed

Address _____ City _____ State _____ Zip _____

Phone Numbers: Cell _____ Home _____ Work _____

Email _____ Preferred Method of Contact: Cell Home Work Email

Occupation _____ Employer _____

Spouse Name _____ Occupation _____

Other family member's names and ages _____

_____

Responsible Party and Insurance Information

Person responsible for this account _____ Relationship to patient _____

Do you have Major Medical Insurance? Yes No

Insurance Carrier _____ Policy # _____

Insured's Name _____ Insured's DOB _____

Insured's SSN _____ Insured's Employer _____

I authorize the release of my medical and/or other information pertaining to my care at Eye Priority.

Print Name _____

Signature _____

Visual History

What is the reason for today's visit? _____

_____

_____

When did these symptoms first begin? _____

Has the problem become better or worse? Please explain _____

_____

Have you had a previous vision evaluation? Yes No

If yes, doctor's name: _____ Date of evaluation _____

Reason for examination: _____

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

If yes, what? _____

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

If no, why not? _____

Were any additional tests, treatments, or therapies recommended concerning your vision? Yes No

If yes, what? _____

Did you undergo these treatments? Yes No Explain: _____

Results and recommendations: _____

Visual Symptom Checklist

- ❑ Headaches
- ❑ Blurred vision at distance
- ❑ Blurred vision at near
- ❑ Double vision at distance
- ❑ Double vision at near
- ❑ Halos around lights
- ❑ Nausea associated with visual tasks
- ❑ Need for very bright light for near tasks
- ❑ Need for very dim light for near tasks
- ❑ Eyes hurt or burn
- ❑ Eyes feel tired
- ❑ Words appear to move or float on the page
- ❑ Motion sickness/car sickness
- ❑ Dizziness
- ❑ Red or itchy eyes
- ❑ Watery eyes
- ❑ Frequent eye rubbing
- ❑ Frequent sties
- ❑ Frequent blinking
- ❑ Closing or covering one eye/squinting
- ❑ Postural changes when doing desk work
- ❑ Head close to paper when reading/writing
- ❑ Avoids reading or other near tasks
- ❑ Tilts head when reading or near task
- ❑ Moves head when reading
- ❑ Can respond better orally than in writing
- ❑ Reverses letters or words
- ❑ Confuses right and left
- ❑ Skips, rereads or omits words
- ❑ Loss of place when reading
- ❑ Skips lines when reading
- ❑ Vocalizes when reading silently
- ❑ Reads slowly
- ❑ Use of finger or object to keep place
- ❑ Poor reading comprehension
- ❑ Comprehension decreases over time
- ❑ Tires easily/visual fatigue
- ❑ Difficulty switching focus from near to far
- ❑ Difficulty sustaining reading or near tasks
- ❑ Falling asleep when reading
- ❑ Remembers better orally than by writing
- ❑ Difficulty aligning columns of numbers
- ❑ Poor time management
- ❑ Short attention span/loses interest
- ❑ Poor general motor coordination
- ❑ Poor fine motor coordination
- ❑ Difficulty with scissors/small hand tools
- ❑ Inconsistent performance in work or sports
- ❑ Difficulty with long-term memory
- ❑ Difficulty with short-term memory

Do you feel your vision hinders your daily activities in any way? Yes No

If yes, how? _____

_____

_____

Have you noticed any eye turn? Yes No (If no, skip to Medical History)

When did you first notice or suspect eye turn? _____

Did the eye begin turning Suddenly Gradually (please circle one)

Does the eye turn In Out Up Down (circle all that apply)

Is the eye turn getting worse or better, or is there no change? _____

_____

Is it always the same eye that turns? Yes No Right Left

Is the eye turn always present? Yes No

If not, under what conditions is it present? (i.e. when tired, when ill, etc.) _____

_____

Is the eye turn noticed more if you are looking:

Up Close	Yes	No	To your right	Yes	No
In distance	Yes	No	Up	Yes	No
To your left	Yes	No	Down	Yes	No

Has there been any treatment using an eye patch? Yes No

If yes, please describe when the patching was started, how patching was done, including the age it started, the eye patched, the duration of treatment, and an estimate of the results. _____

_____

_____

Does the eye turn less when the prescription is worn? Yes No

Does one pupil ever appear to be larger than the other? Yes No

Do you ever notice one or both eyes shaking rapidly? Yes No

Have you ever been told that you have amblyopia (lazy eye)? Yes No

Has there been any surgical treatment? Yes No

If yes, describe the surgery, including the age surgery was performed, the number of operations, the eye operated on, an estimate of the cosmetic and subjective results. _____

_____

Were you satisfied with the results of the surgery? Yes No

Please explain _____

_____

Was the surgeon satisfied with the results of surgery? Yes No

Please explain _____

_____

Medical History

Do you or anyone in your immediate family (parents, grandparents, siblings, children) have any of the following: (Please circle and **INCLUDE** who has/had condition)

- ❑ Autism
- ❑ Brain Tumor
- ❑ Cancer
- ❑ Diabetes
- ❑ Heart Condition
- ❑ High Blood Pressure
- ❑ Multiple Sclerosis
- ❑ Stroke
- ❑ Surgeries
- ❑ Thyroid Conditions
- ❑ Amblyopia
- ❑ Blindness
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Keratoconus
- ❑ Macular Degeneration
- ❑ Strabismus
- ❑ Turned or “lazy” eye
- ❑ Vision related learning disability

Date of most recent medical evaluation:_____ Physician's Name:_____

For what problem / condition? _____

Results and recommendations: _____

List all medications you are currently taking and for what condition: _____

_____

List any vitamins and supplements you are currently taking: _____

_____

Do you have a history of allergies? Yes No

If yes, please explain: _____

Current diet: Excellent Good Fair Poor

Do you smoke? Yes No Do you drink alcohol? Yes No How much?_____

Current state of health (explain): _____

_____

Sports

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: _____

Avoid or do poorly: _____

Hobbies/Leisure Time

Describe the types of activities that comprise the majority of your leisure time:_____

_____

_____

Do you watch TV? Yes No What is the size of the TV you watch?_____Distance from TV?_____

If yes, how many hours per day?_____

How many days per week do you watch TV? _____

Do you play video games? Yes No If yes, which system?_____

How many days per week?_____ How many hours per day? _____

Do you play games on the computer or TV?_____ Distance from TV or computer?_____

Size of TV or Monitor?_____

Do you use a Smart Phone? Yes No If yes, how many hours per day? _____

Computers

When do you use a computer? (circle all that apply) Work School Leisure activity

What types of computer work you perform? (circle all that apply)

Word processing	Internet
Programming	Games/Leisure activities
Data entry	Other (explain) _____
E-mail	_____

What type of computer do you use? (circle all that apply) Laptop Desktop

Please indicate your monitor size_____

What is the distance from:

Your eyes to the screen?_____

Your eyes to the keyboard?_____

Your eyes to your source documents? _____

Where is the top of the screen located? (circle one)

Above eye level

At eye level

Below eye level

Where is the computer screen located when you are seated? (circle one)

Directly in front of you

To your right

To your left

Where are your source documents located?

Directly in front of you when seated	Flat (horizontal)
To your right	Vertical
To your left	

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

Glare from windows or other light sources	Yes	No
Reflections on your computer screen	Yes	No
Difficulty reading source documents	Yes	No

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

Glasses	Yes	No
Contact lenses	Yes	No

Other (explain):_____

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

How do your eyes feel after working at the computer?_____

_____

Employment/School

Current position: _____

Are you currently as student? Yes No If yes, 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 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 of written documents or books? Yes No

Describe briefly your daily activities at work or in school:_____

_____

Is there any other information you feel would be helpful/important as we treat you?

_____

_____

_____

_____

_____

_____

Form Completed by: _____

Name **Relationship to Patient**

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RECORDS RELEASE/REQUEST

TO:_____
(Doctor/Hospital/School)

ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____

I hereby authorize the release of my copied medical records. I request that they be transferred to:

Eye Priority
15725 South 46th Street, Suite 112
Phoenix, AZ 85048
Phone: (480) 893-2300
Fax: (480) 893-0522

_____
Print Name of Patient

From: _____ **To:** _____
Date of Records

_____
Signature of Patient/Parent/Guardian **Date**

This authorization shall be considered valid for 12 months from date signed.