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

ACQUIRED BRAIN INJURY 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 Number Cell _____ Home _____ Work _____

Email _____ Preferred Method of Contact: Cell Home Work Email

Occupation _____ Employer _____

Spouse/Parent Name _____ Occupation _____

Other household 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 gotten better or worse? Please explain _____

_____

Have you had a previous vision evaluation? Yes No
If yes, doctor's name: _____ Date of evaluation _____

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: _____

DO YOU <u>CURRENTLY</u> EXPERIENCE ANY OF THE FOLLOWING:

		Please check if this was a problem prior to injury
☐	Eyes ache	_____
☐	Eyes pull or tug	_____
☐	Difficulty moving or turning eyes	_____
☐	Pain with movement of eyes	_____
☐	Eyes twitch	_____
☐	Eye redness	_____
☐	Burning, itchy or watery eyes	_____
☐	Bothered by brightness/bright lights	_____
☐	Bothered by noises	_____
☐	Bothered by touch	_____
☐	Motion sickness / car sickness	_____
☐	Headaches	_____
☐	Blurred vision	_____
☐	Difficulty changing focus far to near	_____
☐	Double vision	_____
☐	One eye turns in, out, up or down	_____
☐	Movement of objects in the environment is bothersome	_____
☐	Fluorescent light is bothersome	_____
☐	Patterned wallpaper or carpets are bothersome	_____
☐	Head moves when reading	_____
☐	Lose place often when reading	_____
☐	Words jump or move around when reading	_____
☐	Short attention span for reading or writing	_____
☐	Skip words frequently when reading	_____
☐	Discomfort when reading	_____
☐	Loss of interest/concentration when doing close work	_____
☐	Orient writing/drawing poorly on page	_____
☐	Squinting, covering or closing one eye	_____

- ☐ Head tilts during desk work _____
- ☐ Hold books too close _____
- ☐ Avoid reading or writing _____
- ☐ Difficulty with peripheral vision _____
- ☐ Objects jump in and out of field of view _____
- ☐ Reduced depth perception _____
- ☐ Tunnel vision / loss of visual field _____
- ☐ Flashes of light _____
- ☐ Difficulty with dressing _____
- ☐ Difficulty with bathing / personal hygiene _____
- ☐ Difficulty following a series of directions _____
- ☐ Difficulty using both sides of the body together _____
- ☐ Dislike heights _____
- ☐ Awkward, poor balance _____
- ☐ Dizziness _____
- ☐ Confusion / disorientation _____
- ☐ Get lost often _____
- ☐ Bothered by noises _____
- ☐ Bothered by touch _____
- ☐ Difficulty remembering things heard _____
- ☐ Difficulty remembering things seen _____
- ☐ Difficulty remembering name of objects _____
- ☐ Difficulty remembering people's names _____
- ☐ Difficulty recalling information known in the past _____
- ☐ Difficulty remembering formerly familiar people/objects _____
- ☐ Difficulty performing tasks formerly easy/routine _____
- ☐ Difficulty with time management _____
- ☐ Difficulty with numbers _____
- ☐ Difficulty counting money _____

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** whom 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 injury/accident/onset: _____

Type of injury/accident:

- ☐ Blow to head
- ☐ Carbon dioxide
- ☐ Cord around neck
- ☐ Drowning
- ☐ Drug abuse
- ☐ Fall
- ☐ Hemorrhage
- ☐ Industrial Accident
- ☐ Medication-related
- ☐ Motor vehicle
- ☐ Poison or toxic substance
- ☐ Stroke Aneurysm
- ☐ Other _____

What part of your head was affected? (circle all that apply)

Forehead Right side Left side Back of head Top of head Face

Was the injury OPEN HEAD (bleeding) or CLOSED HEAD (non-bleeding)? _____

Did you lose consciousness? Yes No If yes, for how long? _____

Were you in a coma? Yes No If yes, for how long? _____

SYMPTOMS IMMEDIATELY FOLLOWING ACCIDENT/INJURY: (check all that apply)

- ☐ Blurred vision
- ☐ Disorientation
- ☐ Dizziness
- ☐ Double vision
- ☐ Flashes of light
- ☐ Headache
- ☐ Loss of balance
- ☐ Other: _____
- ☐ Loss of memory
- ☐ Neck pain/whiplash
- ☐ Pain in or around eyes
- ☐ Restricted field of view
- ☐ Restricted motion
- ☐ Vomiting

Initial Treatment

When did you first see a doctor regarding your accident/injury? _____

Name of doctor: _____ Specialty: _____

Where were you seen? Hospital Doctor's Office Urgent Care Other: _____

Were you hospitalized? Yes No How long? _____

What were you and your family told? _____

_____

What did the initial treatments consist of? _____

_____

What prognosis/recommendations were you given? _____

Were you given medications? Yes No List Medications: _____

_____

For what condition(s)? _____

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

_____

_____

List any vitamins and supplements you are currently taking: _____

_____

_____

Subsequent or Other Professional Care

What types of professional care have you received or are you currently receiving? (Complete all that apply)

Neurological evaluation? Yes No
If yes, by whom?_____ Date: _____
Results: _____

Psychological evaluation? Yes No
If yes, by whom?_____ Date: _____
Results: _____

Speech and language evaluation? Yes No
If yes, by whom?_____ Date: _____
Results: _____

Neuropsychological evaluation? Yes No
If yes, by whom?_____ Date: _____
Results: _____

Osteopathic evaluation? Yes No
If yes, by whom?_____ Date: _____
Results: _____

Physical therapy evaluation? Yes No
If yes, by whom?_____ Date: _____
Results: _____

Occupational therapy evaluation? Yes No
If yes, by whom?_____ Date: _____
Results: _____

Any other evaluations? Yes No
If yes, by whom?_____ Date: _____
Results: _____

Do you have a history of allergies? Yes No
If yes, please 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 Which system?_____ Size of TV or Monitor?_____

If yes, how many hours per day?_____

How many days per week do you play video or computer games?_____

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

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

Position prior to injury _____ Current position _____

Are you currently a student? Yes No 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 _____

What are your future employment goals? _____

Lifestyle

Do you feel your vision interferes with activities of daily living? Yes No

If yes, please explain (please include effects involving home, work, hobbies, social and personal relationships):

What activities comprise the majority of your daily life since your accident/injury? _____

What activities can you no longer engage in due to your visual or other difficulties? _____

What other changes/limitations in your daily life do you attribute to your accident/injury? _____

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

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.