# ADULT QUESTIONNAIRE

***Please fill out this questionnaire carefully and completely to the best of your ability.***

Appointment:

**GENERAL INFORMATION**

Full Name: ____________________________________________ Gender : ___________

Birth Date: ____________ Age: ______

Home Address: ______________________________________________________________

Email Address:

Preferred Phone: ___________________________ Do you prefer calls, texts, or emails?___________

Were you referred to our office? Yes ☐ No ☐

If yes, whom may we thank for this referral? ____________________________________________

**VISUAL HISTORY**

How long have you had today's vision issue? ______________________________________________

Was it suddenly or gradually? ______________________________________________________

Is it getting worse ☐ or better ☐ or is there no change ☐

Is it always the same eye or both eyes? Yes ☐ No ☐ If yes, which eye? Right ☐ Left ☐

Is the problem always present? Yes ☐ No ☐

Is the problem always the same amount/intensity? Yes ☐ No ☐

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

Have you had any head injuries, falls, accidents or other brain injuries? Yes ☐ No ☐

Do you feel your vision limits your potential in any way? Yes ☐ No ☐

List any other complaints you have concerning vision: ______________________________________

______________________________________________________________________________

Do you experience any of the following:

| | Yes | No | If yes, when? |
|---|---|---|---|
| Headaches | ☐ | ☐ | ______________________ |
| Blurred vision | ☐ | ☐ | ______________________ |
| Double vision | ☐ | ☐ | ______________________ |
| Eyes tired | ☐ | ☐ | ______________________ |
| Eyes hurt | ☐ | ☐ | ______________________ |
| Motion sickness / car sickness | ☐ | ☐ | ______________________ |

Do you experience any of the following:

| | Yes | No | If yes, when? |
|---|---|---|---|
| Frequent styes | ◻ | ◻ | ________________ |
| Red or bloodshot eyes | ◻ | ◻ | ________________ |
| Watery eyes | ◻ | ◻ | ________________ |
| Bothered by light | ◻ | ◻ | ________________ |
| Closing or covering an eye to see better | ◻ | ◻ | ________________ |
| Need to hold paper close when reading or writing | ◻ | ◻ | ________________ |
| Head tilt | ◻ | ◻ | ________________ |
| Confusion of letters or words | ◻ | ◻ | ________________ |
| Skipping or omitting words | ◻ | ◻ | ________________ |
| Loss of place when reading | ◻ | ◻ | ________________ |
| Need to use finger to keep place | ◻ | ◻ | ________________ |
| Poor reading comprehension | ◻ | ◻ | ________________ |
| Comprehension decreases over time | ◻ | ◻ | ________________ |
| Write or print poorly | ◻ | ◻ | ________________ |
| Fatigue easily | ◻ | ◻ | ________________ |
| Difficulty with short term memory | ◻ | ◻ | ________________ |
| Difficulty with long term memory | ◻ | ◻ | ________________ |
| Short attention span / loss of interest | ◻ | ◻ | ________________ |
| Difficulty attending to details | ◻ | ◻ | ________________ |
| Poor / awkward general motor coordination | ◻ | ◻ | ________________ |
| Poor fine motor coordination | ◻ | ◻ | ________________ |
| Difficulty judging distances | ◻ | ◻ | ________________ |
| Difficulty driving | ◻ | ◻ | ________________ |
| Dislike / avoid sports | ◻ | ◻ | ________________ |
| Difficulty hitting or judging moving targets during sports | ◻ | ◻ | ________________ |

**PREVIOUS EVALUATIONS**

Have you had a previous visual evaluation? Yes ◻ No ◻

If yes, Doctor's Name: ________________________ Date of last evaluation: __________

Results and recommendations: ________________________________________

Were glasses, contact lenses, or other optical devices recommended or prescribed? Yes___ No____

If yes, bifocal? ☐ single vision? ☐ contact lenses? ☐ Other? ☐ Explain: ______________________

Are they worn? Yes ☐ No ☐

If yes, when? ______________________________________________

If no, why not? ______________________________________________

Is the problem less when the prescription is worn? Yes ☐ No ☐ Unsure ☐

**HOBBIES/LEISURE TIME**

Describe the types of activities that comprise the majority of your spare 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 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: ______________________________________________

Do you feel your vision limits or prevents you from participating in any activities? Yes ☐ No ☐

If so, explain what and how: ______________________________________________

______________________________________________

Is there any other information that you feel would be helpful / important in our evaluation and/or treatment? Yes ☐ No ☐

If yes, explain: ______________________________________________

______________________________________________

**Release Of Information and Office Policy Agreement**:

It is often beneficial and critical 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 hereby acknowledge that I am aware of the office policies. I authorize the release of medical information to other health care providers upon their written request, or upon the recommendation of PW Optometry when it is necessary for the treatment of my visual condition. This authorization shall be considered valid for the duration of my treatment.

______________________________________________ ____________

Signature of patient Date