CALGARY VISION THERAPY BRENT W. NEUFELD, O.D.
Suite 130 – 4000 Glenmore Court SE, Calgary, AB 403-242-1800 Clinical Director

ADULT BINOCULAR VISION / STRABISMUS /AMBLYOPIA QUESTIONNAIRE

Please fill out this questionnaire carefully and completely and bring it to your scheduled appointment.

Date: _____

GENERAL INFORMATION

Full Name: _____ Male □ Female □
Birth Date: _____ Age: _____
Home Address: _____
City: _____ Postal Code: _____ Occupation: _____
Home Phone: _____ Work Phone: _____
Contact email: _____
Alberta Health Care#_____

Were you referred to our office? Yes □ No □
If yes, whom may we thank for this referral? _____ Phone: _____
Address: _____

What **specific areas of difficulty** does the **individual referring** feel you may be experiencing?
_____
_____
_____

What specific problems are **YOU** noticing/observing?
_____
_____
_____
_____

How long has this problem/difficulty been observed? _____
What are you hoping to determine through this evaluation? _____
_____
_____
_____

MEDICAL HISTORY
List illnesses, bad falls, high fevers, chronic ear infections, hospitalizations etc:
Age Event Severe / Mild Complications
_____
_____
_____
_____
Are you generally healthy? Yes □ No □ If no, explain: _____
Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes □ No □
If yes, please list: _____

Family Doctor (circle): _____ Dateof most recent evaluation: _____
For what problem/condition? _____
Results and recommendations: _____
_____
Current state of health (explain): _____
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: _____
Any history in your family of an eye turn resulting from a disease or other condition? Yes □ No □
If yes, please explain: _____
Was there any related trauma, disease, or condition that preceded or accompanied the onset of the eye turn? Yes □ No □
If yes, please explain: _____
Are you prone to infections? Yes □ No □
Are there any chronic problems like ear infections, asthma, hay fever, allergies? Yes □ No □

Has a neurological evaluation been performed? Yes □ No □
By whom? _____Results: _____
_____

Has an occupational therapy evaluation been performed? Yes □ No □
By whom? _____Results: _____
_____

Have you ever had a CAT scan or MRI? Yes □ No □ If yes, when? _____
Results: _____
_____

FAMILY HISTORY
Is there any **family history** of the following? (please check if there is a history)

	Patient	Family	Who		Patient	Family	Who
Diabetes	□	□	_____	Strabismus / crossed eye	□	□	_____
Multiple Sclerosis	□	□	_____	Amblyopia (lazy eye)	□	□	_____
Blindness	□	□	_____	Thyroid Condition	□	□	_____
Glaucoma	□	□	_____	Cataracts	□	□	_____
High blood pressure	□	□	_____	Brain Tumor	□	□	_____
ADD / ADHD	□	□	_____	Learning Disability	□	□	_____
Other	□	□	_____				

If other, please explain: _____
_____
If ADD/ADHD or a Learning Disability was diagnosed, who diagnosed it, how was it diagnosed and when?
_____
_____

YOUR DEVELOPMENTAL HISTORY
Premature birth? Yes □ No □
Did the mother experience any problems during the pregnancy? Yes □ No □
Normal birth? Yes □ No □
Any complications before, during or immediately following delivery? Yes □ No □
If yes, explain: _____
Were there ever any concerns regarding growth or development? Yes □ No □
If yes, explain: _____

NUTRITIONAL INFORMATION
Current Diet: Excellent □ Good □ Fair □ Poor □
Do you: like □ (or) crave □ sweets? Yes □ No □
Are there any indications that you have been exposed to any toxic substances or fumes? Yes □ No □
If yes, explain: _____

VISUAL HISTORY

IF HAVE AN EYE TURN:

At what age was it first noticed or suspected that an eye was turning? _____

Did the eye begin turning suddenly or gradually? _____

Does the eye turn in □, out □, up □, or down □? (check 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 □ If yes, which eye? Right □ Left □

Is the eye turn always present? Yes □ No □

If no, under what conditions is it present? _____

Does the eye always turn the same amount? Yes □ No □

If no, explain: _____

Do you notice if the eye turns more when you look:

Up close?	Yes □	No □
In the distance?	Yes □	No □
To your left?	Yes □	No □
To your right?	Yes □	No □
Up?	Yes □	No □
Down?	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 □

PRESENT SITUATION

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	□	□	_____
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/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 / lost 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	□	□	_____

List any other complaints you have concerning your vision: _____
_____
_____
_____

Do you feel your vision hinders your daily activities in any way? Yes □ No □
If yes, explain: _____
Do you feel your vision limits your potential in any way? Yes □ No □
If yes, explain: _____
_____

PREVIOUS TREATMENTS

Have you had a previous vision examination? Yes □ No □
If yes, Doctor's Name: _____Date of last visit: _____
Reason for examination: _____
Results and recommendations: _____
_____
Were glasses, contact lenses or other optical devices recommended? Yes □ No □
If yes, Glasses: bifocal□ single vision □;
Contact lenses □
Other □ Explain: _____
Do you use them? Yes □ No □
If yes, when? _____
If no, why not? _____
Does the eye turn less when the prescription is worn? Yes □ No □ Unsure □
Have you been told that you have amblyopia (lazy eye)? Yes □ No □
Has there been any treatment using an eye patch? Yes □ No □
If yes, please describe when the patching was started, how the patching was done, including the age it started, the eye patched, the duration of treatment, and an estimate of the results: _____
_____

PREVIOUS SURGICAL TREATMENT:

Has there been any surgical treatment? Yes □ No □
If yes, please describe the surgery, including the age surgery was performed, the number of operations, the eye(s) operated on, and an estimate of the cosmetic and subjective results: _____
_____
_____
Was the surgeon satisfied with the results? Yes □ No □ Explain:
_____
_____
Were you satisfied with the results of the surgery? Yes □ No □ Explain: _____
_____
Have surgical results been maintained? Yes □ No □ Explain: _____
_____

PREVIOUS VISION THERAPY:

Has there been any visual therapy? Yes □ No □
If yes, Doctor's name: _____
Please describe the type of visual therapy, including duration, the age at which it started and an estimate of results:
_____
_____
_____
Are you here for a second opinion regarding surgery or other treatment? Yes □ No □

VISUAL BEHAVIORS

Does you often cover one eye when looking at near objects? _____ If so, which eye? ____
Does you have a noticeable head tilt? _____
If so, to which side? _____ When was this first noticed? _____
Does you tend to look at objects mostly out of one eye? _____
If so, which eye? _____ When was this first noticed? _____
Do you tend to twist or tilt your head toward a book or object so as to favor one eye? ____
If so, which eye is closer to the object of regard? _____
When was this first noticed? _____
Does you often squint or close one eye when viewing objects? _____
If so, which eye? _____ When was this first noticed? _____
Does you blink or squint excessively? _____
When was this first noticed? _____
Does you rub your eyes during or after short periods of reading? _____

COMPUTERS

Do you use a computer in your work, school, or leisure time activities? Yes □ No □
If so, indicate the types of computer work you perform:

- □ Word processing
- □ Programming
- □ Data entry
- □ Internet
- □ Games / leisure activities
- □ Research
- □ Other (explain): _____

How many hours do you spend in front of a computer screen each day? _____
How many hours do you spend in front of digital devices (including smartphones/tablets)? _____
How do your eyes feel after working at the computer? _____

Where is the top of the screen located?

- □ Above your straight-ahead eye level
- □ At eye level
- □ Below eye level

What is the distance from: Your eyes to the screen? _____
Your eyes to the keyboard? _____
Your eyes to your source documents? _____

Where is the computer screen located?

- □ Directly in front of you when seated
- □ To your right
- □ To your left

Where are your source documents located?

- □ Directly in front of you when seated
- □ To your right
- □ To your left
- □ Flat (horizontal) or vertical

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

- □ Glare from windows or other light sources
- □ Reflections on your computer screen
- □ Difficulty reading source documents

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

- □ Glasses
- □ Contact lenses
- □ Other (explain): _____

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

EMPLOYMENT OR SCHOOL

Current position: _____ 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 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 from the written word? Yes □ No □
Describe briefly your daily activities at work or in school: _____
_____

HOBBIES / SPORTS

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

Do you watch TV? Yes □ No □
If yes, how many hours per day? _____
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: _____
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 / TREATMENT?

_____
_____
_____

RELEASE OF INFORMATION

It is often beneficial for us to discuss examination results and to exchange information with other professionals involved in your care. Please sign the below to authorize the release of information.

I agree to permit information from, or copies of, my examination records to be exchanged with other health care providers when it is necessary for the treatment of my visual condition. If I was referred by an optometrist, I agree to allow Dr. Neufeld send the referring optometrist a summary of the results of the testing along with recommendations given. This authorization shall be valid for the duration of treatment.

_____ _____

Signature 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.

Results will be provided verbally after the evaluation. No written report is included in the evaluation fee. Should a written report be requested, a fee for the time to compose the report will be charged based on the Alberta Association of Optometrists fee guide for detailed letter/report (per hour). Any such requested written reports may take 4-6 weeks.

Please be on time for your examination so that we will have the maximum opportunity to evaluate your visual status. We ask that you find alternate arrangements for looking after any other children (to prevent unnecessary distractions). Please ensure that you have a good night's sleep the night before the appointment and have had something to eat prior to the appointment so hunger will not be a distraction. We are looking forward to meeting you.

For more information on visual training, visit www.calgaryvt.com, www.visiontherapy.com

Please Initial here _____ to confirm you have read these forms and filled them out to the best of your knowledge.

Sincerely,

Brent W. Neufeld, O.D.
Clinical Director
www.calgaryvt.com
https://www.facebook.com/pages/Calgary-Vision-Therapy/335004866603062

All appointments with Dr Neufeld (binocular coordination / strabismus / amblyopia evaluation) is at the Eye Live office: 346, 100 Auburn Meadows Drive SE Calgary, AB T3M 2G5 403-719-5483

Any recommended Vision Therapy services will be at the Calgary Vision Therapy office: 130, 4000 Glenmore Court SE, Calgary, AB T2C 5R8 403-242-1800