Vision Sense
68 Lovett Lake Crt.
Halifax, N.S B3S 1B8
www.Vision-Sense.ca
902.454.1520

# ADULT INTAKE FORM (BV)

**Full Name:** **Preferred Name:**

**Date of Birth (mm/dd/yyyy):** **Age:** **Gender:** Male

**Address:** **Town/City:**

**Province:** NS **Postal Code:** **Email Address:**

**Telephone:** **Mobile:** **Handedness:** Right

**Occupation:** **Employer:**

**Physician:** **Telephone:**

**Optometrist:** **Date of last eye exam:**

**Referred by:** **Profession:**

**Telephone:** **Reason for Referral:**

**Other practitioners or services that you see/use:**

| **Name** | **Profession** | **Telephone** |
|---|---|---|

**What do you expect to learn from the exam?**

**Primary language:** **Additional Languages:**

**What language(s) do you read?** ☐ English ☐ French ☐ Other

**Which language(s) do you write?** ☐ English ☐ French ☐ Other:

**How do you enjoy spending your free time?**

**How many hours per day do you**: Use a Computer Read Watch TV Play Video Games

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**Are there any activities are restricted from doing because of your vision?** No

If yes, what?

**Does your job include using a computer?** No **If yes, how many hours per day?**

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**PRESENT SITUATION AND VISUAL HISTORY:**

**In what ways are you having visual difficulty?**

**How long has difficulty been noticed?**

**Previous visual examinations:**

| Reason for exam | Doctor's Name | Date | Result |
|---|---|---|---|

**Do you wear glasses, contact lenses, and/or use a special optical device?** No

If yes, what?

Do you wear them regularly? No

If no, why?

**Have you had problems wearing contacts?** No

Describe:

**Have you had any eye surgeries?** No

Type:

**Surgeon:**

Date:

**Do you have any family members who have required visual attention?**

| Relationship | Age | Visual Situation |
|---|---|---|

**Has anyone noticed an eye turn in or wander out?** No

Describe:

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**Do you ever experience any of the following, and if yes, when?**

- ☐ Headaches
- ☐ Blurred Vision Far
- ☐ Blurred at Near
- ☐ Eyes sore or tired
- ☐ Double Vision
- ☐ Light sensitivity

**Have you ever noticed any of the following?**

- Holding reading close? ☐
- Holding reading further away? ☐
- Closing one eye? ☐
- Covering one eye? ☐
- Eyes frequently reddened? ☐
- Frequent styes? ☐
- Excessive eye rubbing? ☐
- Lose your spot in a book? ☐
- Tilting head when reading? ☐
- Inability to see distance objects? ☐
- Bumping into objects? ☐
- Poor general coordination? ☐
- Have you had any eye surgeries? ☐
- Have you ever had vision therapy? ☐
- Have you ever injured your eyes? ☐
- Bothered by light? ☐

**Please check the conditions if they apply to you or run in your family:**

| **Systemic Disease/Condition** | **Relationship** | **Ocular Disease/Condition** | **Relationship** |
|---|---|---|---|
| ☐ Arthritis | | ☐ Lazy eye | |
| ☐ Diabetes | | ☐ Turned eye | |
| ☐ Rheumatoid Arthritis | | ☐ Color “blind” | |
| ☐ Fever | | ☐ Light sensitive | |
| ☐ Weight loss/gain | | ☐ Eyestrain | |
| ☐ Cancer | | ☐ Dry eyes | |
| ☐ Diabetes | | ☐ Floaters/spots | |
| ☐ Drug sensitive | | ☐ Flashing lights | |

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- [ ] Elevated cholesterol
- [ ] Heart problem/disease
- [ ] High blood pressure
- [ ] Thyroid
- [ ] Migraine or Headaches
- [ ] Skin (acne, cancer)
- [ ] Gastrointestinal
- [ ] Urogenital (kidney, bladder)
- [ ] Neurological (MS, seizures)
- [ ] Allergies
- [ ] Kidney Disease
- [ ] Other

- [ ] Retinal detachment or disease
- [ ] Blindness
- [ ] Macular degeneration
- [ ] Cataracts
- [ ] Crossed Eyes
- [ ] Glaucoma
- [ ] Head trauma
- [ ] Eye surgery
- [ ] Psychiatric
- [ ] Respiratory
- [ ] Lupus

**Date of your last physical exam?**

**How is your general health?** Excellent

**Please list any medications you are regularly taking:**

**Allergies:**

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| **List any major illnesses:** | Age | Mild | Severe |
|---|---|---|---|
| | | ☐ | ☐ |
| | | ☐ | ☐ |
| | | ☐ | ☐ |

**Do you have any chronic health problems?** No

**Do you use a mobility aid? If yes, what?** No

**How is your current diet?** Excellent

Explain:

**Have you had an acquired brain injury/or concussion?** No
If yes, please complete the *Brain Injury Intake Form*

As you completed this medical history questionnaire, you likely recognized the thoroughness with which your conditions will be considered. The office examination will take up enough time to permit a very complete optometric investigation of any problem. I am looking forward to meeting you and helping you meet your visual needs.

**I authorize the release of medical and/or other information pertinent to my care to the insurance company in order for me to be reimbursed.**

**Signature**: _____ **Date**: _____