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ADULT VISION QUESTIONNAIRE

Please fill out this questionnaire and return it to our office at least 48 hours prior to your appointment. Thank you.

Patient's full name: ______________________ Date of Birth: ______________________

Address: ______________________ Phone number: ______________________

______________________ Email: ______________________

Health Card Number: ______________________ Version Code: __________ Expiry: __________

Credit Card Number: ______________________ Expiry: __________ Security Code: __________

Name on Credit Card: ______________________ Billing Address: ______________________

Were you referred to our clinic? ☐ Yes ☐ No

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

MEDICAL HISTORY

Family Doctor: ______________________ Family Doctor Phone Number: ______________________

Allergies: ______________________

Medical conditions: ______________________

____

Medications (incl. vitamins/supplements): ______________________

____

Do any eye diseases run in the family? ______________________

____

OCCUPATION

Occupation: ______________________ Employer: ______________________

Percentage of your day spent on electronics (i.e. computer, phone, etc): ______________________

VISUAL HISTORY

Main reason for having an examination today? ______________________

____

____

Date of last eye exam: ________________________________Optometrist: ______________________________

Please describe any previous eye or vision problems and treatment you have received (including glasses, vision therapy, patching, surgery, medications, etc.): ____

____

____

Do you wear any of the following: (Please check all that apply)

☐ Distance glasses	☐ Progressive glasses	☐ Sunglasses
☐ Reading glasses	☐ Bifocal/Trifocal glasses	☐ Contact lenses (brand: __________)

When did you begin wearing glasses? ______________________

Do you feel your glasses/contact lenses are working well for you? ☐ Yes ☐ No

Do you experience any of the following: (Please check all that apply)

☐ Headaches	☐ Double Vision	☐ Crossed or wandering eye
☐ Blurred Vision (near)	☐ Eyes hurt or tired	☐ Difficulty tracking an object
☐ Blurred Vision (far)	☐ Squinting	☐ Closes or covers one eye
☐ Tilts head	☐ Motion/car sickness	☐ Burning, itching or tearing
☐ Light sensitivity	☐ Focus goes in and out	☐ Nausea with visual tasks
☐ Difficulties with memory	☐ Loses attention easily	☐ Vocalizes when reading
☐ Avoids reading	☐ Holds book really close	☐ Confuses left and right
☐ Poor, inefficient reading	☐ Skips, rereads or omits words/lines	☐ Poor spelling
☐ Loses place while reading		☐ Poor handwriting
☐ Poor reading comprehension	☐ Words moving/running together	☐ Frequent letter, number or word reversals
☐ Uses finger to track along line when reading	☐ Difficulty looking from one distance to another	☐ Math difficulty (facts/concepts)

FURTHER INFORMATION

Is there anything else you would like to tell us? ____

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PLEASE BRING YOUR CURRENT GLASSES AND SUNGLASSES TO YOUR EXAM