

Dr. Emily Schottman
Developmental Optometrist
Summer Beathe
Vision Therapist



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DEVELOPMENTAL VISION EVALUATION QUESTIONNAIRE - ADULT

Thank you for carefully completing this questionnaire, to personalize your care.
Questionnaire must be filled out and returned one week prior to your appointment.
Appointments without a questionnaire submitted will need to be rescheduled.

Patient's Name: _____ Developmental Vision Evaluation Date: _____ Time: _____
Date of Birth: _____ Age: __ yrs. Gender: Male Female Marital Status: Single Married Divorced Widowed
If applicable, list your spouse and dependents: Spouse: _____ Birth Date: _____
Dependent(s): _____ Birth Date(s): _____
Were you referred to us? Yes No If you were referred, whom may we thank? _____
Referral Type: Doctor Therapist Tutor/Teacher Family Friend Other: _____
If not referred, how did you hear about us? _____

CONTACT INFORMATION

Home Address: _____ City: _____ Zip: _____
Home Phone: _____ Email: _____ Cell Phone: _____
Person to Contact in Case of Emergency: _____ Cell Phone: _____
Employer: _____ What is your Occupation? _____
Business Address: _____ Business Phone: _____

MEDICAL HISTORY

Physician's Name: _____ Date of most recent evaluation: _____
For what problem/condition? _____
Results and recommendations: _____
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: _____
Current diet: Excellent Good Fair Poor Current state of health (explain): _____
Do you have any chronic problems like ear infections, asthma, hay fever, allergies? Yes No
If "Yes," please list: _____

List any illnesses, injuries or hospitalizations below.

Age	Diagnosis	Complications

Other Medical Information that you feel is significant? _____

Family Medical History (Please check if there is any history of the following.)

	<u>Patient</u>	<u>Family</u>	<u>If Family, Who?</u>		<u>Patient</u>	<u>Family</u>	<u>If Family, Who?</u>
Poor Vision/Hi Rx	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Strabismus (eye turn)	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dyslexia/Learning Issue	<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Brain Tumor	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

If other, please explain: _____

Medical History - Extended

Did you have any significant injuries, surgeries or treatment as a child? _____

Did you experience any developmental (age to crawl/walk/talk) or learning delays? _____

Have you ever had any of the following types of evaluations?

Neurological : When? _____ By whom? _____

Results and recommendations: _____

Psychological : When? _____ By whom? _____

Results and recommendations: _____

Chiropractic : When? _____ By whom? _____

Results and recommendations: _____

Other Medical Information that you feel is significant? _____

VISUAL HISTORY

Why do you feel the need for a Visual Evaluation? _____

How long has this problem/difficulty existed? _____

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: _____

Have you had a previous vision examination? Yes No If "Yes," Doctor's Name: _____ Date: _____

Results and recommendations: _____

Do you wear: Glasses Contacts Both Worn for which activities? _____

Have you ever had Vision Therapy or Vision Training? Yes No Doctor's Name and City: _____

Please describe the age at which you started, how long you participated and an estimate of results: _____

Do you notice any of the following visual symptoms? (Note: many of these symptoms fall into more than one category)

Prescription/ Eye Focusing (Accommodation) Problem

- Blurry vision when looking between near and far distances
- Eyestrain, fatigue, headaches
- Can't read for very long, avoid reading
- Red eyes or lids
- Excessive watering of eyes
- Must blink a lot

Eye Tracking (Ocular Motility) Problem

- Skip words when you read
- Must reread to understand, especially when tired
- Use finger or marker when reading
- Lose your place when reading
- Head movements when you read
- Misalign columns of numbers

Eye Teaming (Binocularity) Problem

- See double, especially when tired
- Cover or close one eye when reading or writing
- One eye turns in/out when tired
- Tilt or turn your head to see better
- Poor posture
- Squint or Rub eyes
- Letters or lines "float" "run together," or "jump around"
- Eyestrain or fatigue, especially at end of day

Visual Motor Problem

- Write or print poorly
- Poor eye-hand coordination
- Clumsy, accident-prone
- Difficulty judging distances or objects
- Poor driver
- Dislike/avoid sports

Visual Information-Processing Problem

- Have to work harder than everyone else
- Reading and Learning don't come easy for me.
- Poor ability to remember what is read
- Learn better when "hear" the information
- Difficulty remembering what people tell you
- Poor time management, always running behind
- Poor printing or handwriting
- Short attention span, distractible
- Move your lips when you read
- Confuse "right" and "left" directions
- Short attention span / loss of interest
- Difficulty attending to details
- School or work performance not up to potential

READING/COMPUTERS

Do you like to read? Yes No

How long are you able to read until your eyes bother you? _____

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 Other (explain): _____

How many hours do you spent in front of a computer screen each day? _____

How do your eyes feel after working at the computer? _____

Where is the computer monitor located? Directly in front of you To your right To your left 2 or more monitors

Where is the top of the screen located? Above your eyes At eye level Below eye level

What is the distance (in inches) from your eyes to the: Monitor? _____ Keyboard? _____ Any reference documents? _____

If you refer to documents, where are they located? To your right To your left Flat (horizontal) or vertical

Do you notice glare/reflections from your: Monitor Windows Lighting Other _____

Do any of the following body parts ache/hurt after working on the computer? Neck Face Back Arm Hand

Leg Other _____ Describe the sensation. _____

Do you wear glasses or contact lenses 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: _____

Describe briefly your daily activities at work or in school: _____

What are your biggest challenges with these activities? _____

How many hours daily do you spend at a desk? _____

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 an increasing need for more effort to accomplish tasks? Yes No

If "Yes," please explain: _____

HOBBIES/SPORTS

Describe the types of activities you like to do in your leisure time: _____

Do you watch TV? Yes No If "Yes," how many hours per day? _____ Days per week? _____

Do you participate in sports or outdoor activities? Yes No

Do you feel challenged or uncoordinated in sports or athletic activities? 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: _____

And Lastly....

Please describe yourself as a person. _____

What are your goals for this Vision Evaluation and/or Vision Training? _____

Is there any further information you would like to provide to assist in your eye care treatment? _____

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us. You may leave a message for us 24 hours a day/7 days a week.

We require a minimum of 24 hours notice if you are unable to keep this appointment. **If < 24 hours, there is a \$45 rescheduling fee to reappoint a missed appointment. A missed initial appointment with no notice will not be rescheduled.**

Please be on time for your appointment, so that we will have the maximum opportunity to evaluate your vision. Please do not bring any children with you because your undivided attention is necessary during the evaluation.

We are looking forward to meeting you.

Thank you.



Dr. Emily Schottman

Developmental Optometrist

Developmental Optometrists specialize in the testing and training of visual skills necessary for efficient vision in school, work and sports, providing a more enjoyable quality of life.

STRABISMUS/AMBLYOPIA ADDENDUM

(Please complete if applicable)

Have you been told that you have Amblyopia (lazy eye)? Yes No If "Yes," at what age? _____

Have you been told that you have Strabismus (eye turn)? Yes No If "Yes," at what age? _____

Have you had an eye surgery? Yes No If "Yes," please describe the surgery, including the age surgery was performed, the number of operations, the eye(s) operated on: _____

Was the surgeon satisfied with the results of surgery? Yes No Explain: _____

Were you satisfied with the results of surgery? Yes No Explain: _____

Have surgical results been maintained? Yes No Explain: _____

Are you here for a second opinion regarding surgery or other treatment? Yes No

IF YOUR EYE TURNS:

▪ Did it begin turning suddenly or gradually ? Explain: _____

NOTE: A SUDDEN EYE TURN MAY BE DUE A SERIOUS MEDICAL EMERGENCY AND REQUIRES IMMEDIATE MEDICAL ATTENTION. CALL 911.

▪ 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 your eye turn less (or vision improve) when the prescription is worn? Yes No Unsure

Have you ever used an eye patch? Yes No

If "Yes," please describe your age when the patching was started, how the patching was done and for how long, the eye patched, and an estimate of the results: _____

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

What is your best corrected vision, if known? _____

What are your biggest concerns regarding your Strabismus or Amblyopia? _____

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RELEASE OF INFORMATION AND INSURANCE FILING

It is often beneficial for us to discuss examination results and to exchange information with other professionals involved in your care. Please sign 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 or provided to insurance carriers upon their written request or upon the recommendation of the STARS IN YOUR EYES OPTOMETRY when it is necessary for the treatment of my visual condition, or for the processing of insurance claims. This authorization shall be valid for the duration of treatment.

Signature or Authorized Representative

Date