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BEYOND TRADITIONAL VISION CARE

IMPORTANT: *The information on this intake form will enable the doctor to ascertain and evaluate your needs most effectively. Please fill out the following as completely as possible and* ***PLAN 45 MINUTES TO 1 HOUR*** *for the initial examination. We look forward to meeting you!*

INSTRUCTIONS: *1) Using your computer, you may type directly on this form.* ***PRINT A HARD COPY*** *in case there are e-mail submission issues. E-mail the form to us by clicking the "submit" button OR, 2) print this form and write the information directly in the spaces provided. Fax or mail the completed form to the fax number or address in the upper right-hand corner. PLEASE forward any other pertinent records to our office after this form has been submitted.*

I. Patient Information

Last name First Called by

Birth date Month Day Year Age ☐ Male ☐ Female

Street address

City State Zip E-mail

Home phone ( ) Mobile phone ( )

Work phone ( ) Who referred you to us?

II. Present Situation

Reason for evaluation:
Type here:

Did the problem(s) occur suddenly?
Type here:

Do the problems seem to be related to illness, accident, or other trauma?
Type here:

A small photo is useful for our files. Please bring one with you to the examination OR insert a digital image. For successful e-mailing capacity It must be 150K or less @ 72dpi.

INSERT IMAGE HERE

III. Current Symptoms

	Never	Sometimes	Often	Difficulty with:	Never	Sometimes	Often
Dizziness	☐	☐	☐	Reading	☐	☐	☐
Disorientation	☐	☐	☐	Speaking	☐	☐	☐
Tunnel vision	☐	☐	☐	Writing	☐	☐	☐
Loss of balance	☐	☐	☐	Maintaining attention	☐	☐	☐
Fatigue	☐	☐	☐	Judging space	☐	☐	☐
Blurry vision	☐	☐	☐	Motor planning	☐	☐	☐
Seeing spots	☐	☐	☐	Short term memory	☐	☐	☐
Trouble walking	☐	☐	☐	Long term memory	☐	☐	☐

Please comment on any long term problems during school years or in past history. (Example: couldn't spell or understand geometry)
Type here:

IV. Visual History

Do you experience problems with:	Yes	Sometimes	No		Yes	Sometimes	No
Headaches	☐	☐	☐	Trouble with close work	☐	☐	☐
Blurred vision (far)	☐	☐	☐	Reading	☐	☐	☐
Blurred vision (near)	☐	☐	☐	Using the computer	☐	☐	☐
Double vision	☐	☐	☐	Doing hobbies	☐	☐	☐
Eye strain	☐	☐	☐	Participating in competitive sports	☐	☐	☐
Light sensitivity when driving				Wearing sports goggles	☐	☐	☐
in bright sunlight	☐	☐	☐	Glare	☐	☐	☐

Have you been noticing:

Itchy eyes	☐	☐	☐	Red eyes	☐	☐	☐
Sties	☐	☐	☐	Sitting too close to the TV	☐	☐	☐
Excessive blinking	☐	☐	☐	Watery eyes	☐	☐	☐

When you read or write do you:	Yes	Sometimes	No	Do you:	Yes	Sometimes	No
Reverse letters or numbers	☐	☐	☐	Close or cover one eye	☐	☐	☐
Transpose words	☐	☐	☐	Tilt or turn head	☐	☐	☐
Skip or repeat words	☐	☐	☐	Distort face muscles	☐	☐	☐
Keep place with finger	☐	☐	☐	Have an awkward posture	☐	☐	☐
Move lips	☐	☐	☐				
Move head excessively	☐	☐	☐	Maintain concentration			
Lose place on page	☐	☐	☐	for a long period of time?	☐	☐	☐

Any other information? (example: When and how often do these symptoms occur?)
Type here:

IV. Visual History (continued)

Have you had any unusual visual attention or care? ☐ Yes ☐ No Describe:__________

Do you have glasses now? ☐ Yes ☐ No Do you wear them? ☐ Yes ☐ No

If yes, when should you wear them? When was the last time your lenses were changed?

Do you wear contact lenses? ☐ Yes ☐ No What brand are they?

How often do you wear your lenses?

How many hours per day do you wear your lenses?

How often do you change your lenses?

I wear eyewear or contact lenses during these situations:

business/workday	☐ glasses	☐ contacts
weekend/evening	☐ glasses	☐ contacts
casual/recreation	☐ glasses	☐ contacts
social events	☐ glasses	☐ contacts
outdoor activities	☐ glasses	☐ contacts

V. Speech - Auditory History

	Yes	No		Yes	No
Is your speech clear?	☐	☐	Do you omit of parts of words	☐	☐
Can you express thoughts clearly?	☐	☐	Do you stutter	☐	☐
Do you turn your head to one side to listen?	☐	☐	Is speech understandable by others?	☐	☐
Do you often say "huh"?	☐	☐	Are there any unusual patterns of speech	☐	☐

If you answered yes to unusual patterns of speech, please describe:

What other language(s) are spoken?

VI. Medical History

	Yes	No		Yes	No
Diabetic	☐	☐	Asthmatic	☐	☐
Epileptic	☐	☐	Allergies	☐	☐

What are the allergies?

Type here:

Signature Date

We will ask you to sign this form at your first visit.

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