J. Robert Walesby, O.D.,F.C.O.V.D.
Shereé Wright, O.D.

WALESBY VISION CENTER
"Where Vision Is More Than Just 20/20"

Nicholas Thomas, O.D., F.C.O.V.D.
Clinical Director of Vision Therapy

ADULT VISION QUESTIONNAIRE – EXTENDED

*Please fill out this questionnaire carefully and completely and submit it to our office **FOUR BUSINESS DAYS PRIOR** to your Screening or Work-Up appointment. Thank you.*

Appointment: Day:_____ Date: _____Time: _____

Patient's Name: _____

How did you hear about us?

- ☐ Referred by_____ Reason: _____
- ☐ Internet (specify)_____ ☐ Insurance (Carrier) _____
- ☐ Yellow Pages/ White Pages ☐ Television
- ☐ Drive by ☐ Other (specify)_____

GENERAL INFORMATION

Full Name:_____ ☐ Male ☐ Female
Birth Date:_____Age:_____Social Security Number: _____
Home Address:_____City:_____Zip:_____
Primary Phone:( ) _____ Alt. Phone: ( )_____ Fax: ( ) _____
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
What is your occupation? _____Employer: _____
Spouse's Name: _____Occupation: _____
Spouse's Employer: _____Phone #: ( )_____

FAMILY MEMBERS

NAME

Spouse:_____Birth Date:_____
Dependent:_____Birth Date:_____
Dependent:_____Birth Date:_____
Dependent:_____Birth Date:_____

MEDICAL HISTORY

Physician: _____Date of Last Evaluation: _____
Reason for Visit: _____
Results and recommendations: _____
Current medications, 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): _____

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Is there any history of the following? (please check if there is a history)

	Patient	Family (Who)		Patient	Family (Who)
Diabetes	☐	☐	High Blood Pressure	☐	☐
"Cross" or "Wall" eye	☐	☐	Learning Disability	☐	☐
Chromosomal Imbalance	☐	☐	Amblyopia (lazy eye)	☐	☐
Glaucoma	☐	☐	Multiple Sclerosis	☐	☐
Brain Tumor	☐	☐	Epilepsy or Seizures	☐	☐
			Other	☐	☐

VISUAL HISTORY

Has his/her vision been previously evaluated? Yes ☐ No ☐
If so, Doctor's Name: _____ Date of last evaluation: _____
Reason for examination: _____
Results and recommendations: _____
Were glasses, contact lenses, or other optical devices recommended? Yes ☐ No ☐
If yes, what? _____
Are they worn currently? Yes ☐ Full time ☐ Distance only ☐ Near only ☐
No ☐ Explain: _____
Do you wear contacts lenses Yes ☐ No ☐ How many years? _____
What type of contacts do you wear? Soft ☐ Gas permeable (hard) ☐ Disposable ☐
Other (specify) _____ What solutions do you use? _____

Members of the family who have had visual attention (i.e. surgery) and the reason:

Procedure	Age	Treatment/ Condition/

PRESENT SITUATION

Why do you feel you need a visual evaluation? _____

_____

_____

How long has this problem/difficulty been observed? _____

Do you experience any of the following:

	Yes	No	If yes, when?
Blurred vision at distance	☐	☐	
Blurred vision at near	☐	☐	
Red or itchy eyes	☐	☐	
Burning eyes	☐	☐	
Frequent Sty(s)	☐	☐	
Watery eyes	☐	☐	
Eyes hurt	☐	☐	
Eyes feel tired	☐	☐	
Headaches	☐	☐	

	Yes	No	If yes, when?
Nausea associated with visual tasks	☐	☐	
Halos around lights	☐	☐	
Double vision at distance	☐	☐	
Double vision at near	☐	☐	
Tilt head during desk work	☐	☐	
Squinting, covering or closing one eye	☐	☐	
Postural changes when doing desk work	☐	☐	
Need for very bright light when reading	☐	☐	
Need for very dim light when reading	☐	☐	
Loss of interest or short attention span for close work	☐	☐	
Difficulty sustaining reading / writing	☐	☐	
General or visual fatigue at the end of the day	☐	☐	
Loss of place often when reading	☐	☐	
Skip lines when reading	☐	☐	
Repetition of letter or words when reading	☐	☐	
Omission of words when reading / copying	☐	☐	
Use of finger to keep place	☐	☐	
Head moves when reading	☐	☐	
Confusion of what is being seen or read	☐	☐	
Falling asleep when reading	☐	☐	
Silent vocalization/moving lips while reading	☐	☐	
Motion / car sickness	☐	☐	
Difficulty with reading comprehension	☐	☐	
Comprehension decreases over time	☐	☐	
Letters or words appear to move or float around when reading	☐	☐	
Difficulty aligning columns of numbers	☐	☐	
Can respond better orally than in writing	☐	☐	
Write or print poorly	☐	☐	
Poor time management	☐	☐	
Inconsistent performance in work or sports	☐	☐	
Poor general coordination / clumsiness	☐	☐	
Poor fine motor coordination	☐	☐	
Difficulties with short-term memory	☐	☐	
Difficulties with long-term memory	☐	☐	

Comments on any items above: _____

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
- ☐ Data entry
- ☐ Games / Leisure activities
- ☐ Other (explain): _____
- ☐ Programming
- ☐ Internet

How many hours are you on a computer daily?___ 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

Where is the computer screen located?

☐ Directly in front of you when seated ☐To your right ☐To your left

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

Where are your source documents located?

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

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 (specify): _____

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 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 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? _____

How many days per week? _____

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: _____

PLEASE INCLUDE ANY ADDITIONAL INFORMATION THAT YOU MAY FEEL HELPFUL IN YOUR TREATMENT/ DIAGNOSIS:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

RELEASE OF INFORMATION AND INSURANCE FILING

IT IS OFTEN BENEFICIAL FOR US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION REGARDING YOUR CARE. PLEASE SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION.

I agree to permit information from, or copies of my examination records to be forwarded to other health care providers or insurance carriers upon written request or recommendation of the WALESBY VISION CENTER when deemed necessary for treatment of my visual condition, or processing of insurance claims.

_____ _____

Signature of patient or authorized representative Date

This authorization is valid for the duration of treatment. Thank you for carefully completing this questionnaire. The information provided allows for a more efficient use of time, enabling us to perform a more comprehensive evaluation and better meet his/her specific visual needs.

If you have questions or concerns prior to your appointment, please do not hesitate to contact us.

A minimum cancellation notice of 48 hours is required, as previously agreed, or a $360 service charge will be processed. You may leave a voicemail at our office number at any time.

Please be prompt for the appointment, in order to maximize the time reserved to evaluate his/her visual status.

Your undivided attention is necessary during this evaluation; it is, therefore, advisable not to bring other children.

Your child may benefit from bringing something to occupy his/her time while you are in conference with the doctor.

Sincerely,

J. Robert Walesby, O.D., F.C.O.V.D.
Shereé Wright, O.D

Nicholas Thomas, O.D., F.C.O.V.D.
Clinical Director of Vision Therapy

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