INDIANA VISION
Development Center, PC

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DATE _____

PATIENT FULL NAME _____
COMPLETE ADDRESS _____
PRIMARY PHONE_____ SECONDARY PHONE _____
OCCUPATION _____ DOB _____ AGE NOW _____
EMAIL: _____

HOW DID YOU HEAR ABOUT US? _____
****

PRESENT SITUATION: IN WHAT WAYS ARE YOU HAVING VISUAL DIFFICULTY?

_____
_____
_____

HAS ANYONE NOTICED AN EYE TURN IN ___ OUT ___ WHICH EYE? ___ WHEN? _____

DO YOU EVER HAVE ANY OF THE FOLLOWING, AND IF SO, WHEN?

HEADACHES YES _____ NO _____ WHEN? _____
BLURRED AT FAR YES _____ NO _____ WHEN? _____
BLURRED AT NEAR YES _____ NO _____ WHEN? _____
DOUBLE VISION YES _____ NO _____ WHEN? _____
EYES TIRED OR HURT YES _____ NO _____ WHEN? _____

HAVE YOU EVER NOTICED THE FOLLOWING?

HOLDING READING CLOSE YES _____ NO _____ WHEN? _____
HOLDING READING FAR YES _____ NO _____ WHEN? _____
CLOSING ONE EYE YES _____ NO _____ WHEN? _____
COVERING ONE EYE YES _____ NO _____ WHEN? _____
EYES OFTEN RED YES _____ NO _____ WHEN? _____
FREQUENT STY'S YES _____ NO _____ WHEN? _____
EXCESSIVE EYE RUBBING YES _____ NO _____ WHEN? _____
GET LOST IN BOOK YES _____ NO _____ WHEN? _____
READS WITH FINGERS YES _____ NO _____ WHEN? _____
POOR READING POSTURE YES _____ NO _____ WHEN? _____
READING IN BED YES _____ NO _____ WHEN? _____
UNABLE TO SEE DISTANCE YES _____ NO _____ WHEN? _____
BUMPS INTO OBJECTS YES _____ NO _____ WHEN? _____
POOR COORDINATION YES _____ NO _____ WHEN? _____
BOTHERED BY LIGHT YES _____ NO _____ WHEN? _____

(continue on back of form)

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DOES YOUR JOB INCLUDE USING A VIDEO TERMINAL? Y/N ____ HOW LONG? _____

DID YOU LIKE SCHOOL? Y/N _____ WAS GRADE REPEATED? _____ WHICH? _____

WAS YOUR WORK AVERAGE? ____ABOVE AVERAGE? ____ BELOW AVERAGE? _____

WHAT WAS MOST EASY FOR YOU? _____

WHAT WAS MOST DIFFICULT FOR YOU? _____

HOW DO YOU LIKE TO SPEND YOUR FREE TIME? _____

_____

_____

****

HEALTH HISTORY:

LIST ANY MAJOR ILLNESSES: AGE MILD SEVERE

_____

_____

_____

PRESENT MEDICATIONS: _____

LIST ANY ALLERGIES: _____

VISUAL HISTORY:

HOW LONG HAS YOUR DIFFICULTY BEEN NOTICED? _____

_____

PREVIOUS VISUAL EXAMINATION:

REASON FOR EXAMINATION DOCTOR DATE RESULTS

_____

_____

_____

FAMILY MEMBERS WHO HAVE HAD VISUAL ATTENTION AND WHY:

NAME AGE VISUAL SITUATION

_____

_____

_____

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

In order for us to keep costs down, payment is expected in full at the time of service.

Signature _____ **Date** _____