

WELCOME TO OUR OFFICE



VALLEY VISION
OPTOMETRY

Patient Information

Last name _____
 First name _____
 Care Card # _____
 Date of birth _____
 Email address _____

What is the major purpose of this visit?

Any problems with your current contact lenses or glasses?

Lifestyle Questions

Grade / Occupation _____
Do you.....(check box if your answer is yes)
..use a computer? If yes, number of hours on the computer_____. Distance from computer_____. Do you see it comfortably with your glasses? Yes No
..drive? If yes, what class(es)?_____. Are you required to wear corrective eyewear?_____.
..think you might benefit from thinner, lighter lenses?
..have interest in a “test drive” of the latest contact lens designs?
..have interest in changing your eye colour?
..spend time outdoors? How much?_____hours/week.
..have prescription sunwear?
..prefer not to wear your glasses at times?
..want information on Laser Vision Correction surgery?
..have more than 1 pair of **current** Rx eyewear?
..have family members in need of eyecare?

Activities

Outdoor Leisure	Indoor Leisure	Sports
<input type="checkbox"/> ..Fishing	<input type="checkbox"/> ..Crafting	<input type="checkbox"/> ..Basketball
<input type="checkbox"/> ..Golf	<input type="checkbox"/> ..Movies	<input type="checkbox"/> ..Biking
<input type="checkbox"/> ..Hiking	<input type="checkbox"/> ..Music	<input type="checkbox"/> ..Football
<input type="checkbox"/> ..Hunting	<input type="checkbox"/> ..Needlework	<input type="checkbox"/> ..Hockey
<input type="checkbox"/> ..Skiing	<input type="checkbox"/> ..Reading	<input type="checkbox"/> ..Jogging
<input type="checkbox"/> ..Walking	<input type="checkbox"/> ..Video Games	<input type="checkbox"/> ..Racquetball
<input type="checkbox"/> ..Yardwork	<input type="checkbox"/> ..Woodworking	<input type="checkbox"/> ..Soccer
		<input type="checkbox"/> ..Swimming
<input type="checkbox"/> ..Safety eyewear required		<input type="checkbox"/> ..Volleyball

Patient Eye History

Date of Last Eye Exam _____
 By Whom? _____
 Do you currently wear glasses? Yes No
 Planning to update your eyeglasses? Yes No
 Have you ever tried contact lenses Yes No
 Do you currently wear contact lenses? Yes No
 What kind? _____
 Solutions used _____
 Rewetting drops used _____
 Wearing time _____ (hours/day, days/week)

Are you satisfied with the...
 ...vision with contacts? Yes No
 ...comfort with contacts? Yes No

If you no longer wear contact lenses, why did you discontinue their use? _____

Have you experienced, been diagnosed or treated for any of the following?

<input type="checkbox"/> Amblyopia (lazy eye)	<input type="checkbox"/> Blurry near vision
<input type="checkbox"/> Blurry distance vision	<input type="checkbox"/> Burning
<input type="checkbox"/> Cataract	<input type="checkbox"/> Corneal disease
<input type="checkbox"/> Double vision	<input type="checkbox"/> Dry eye
<input type="checkbox"/> Eye infection	<input type="checkbox"/> Eye injury
<input type="checkbox"/> Flashes of light	<input type="checkbox"/> Floaters/spots
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Grittiness
<input type="checkbox"/> Headache	<input type="checkbox"/> Iritis / Uveitis
<input type="checkbox"/> Itchiness	<input type="checkbox"/> Macular degeneration
<input type="checkbox"/> Retinal detachment	<input type="checkbox"/> Strabismus (eye turn)
<input type="checkbox"/> Sunlight sensitivity	<input type="checkbox"/> Tearing
<input type="checkbox"/> Trouble seeing at night	<input type="checkbox"/> Uncomfortable glasses
<input type="checkbox"/> Other eye disorders _____	

Please list any eye surgeries you have had.

Year	Surgery	Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Date of last visit to your family doctor: _____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please list environmental and medication allergies: _____

Do you smoke? Yes No

Have you ever been diagnosed or treated for the following?

	Yes	No
Acid reflux	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol / dyslipidemia	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Eczema / Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Hypothyroid	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Traumatic brain injury	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>

Other health problems: _____

School Performance

In order to assist the doctor in evaluating visual skills needed in the learning environment, please grade and then check all boxes that apply:

1 - below average 2 - average 3 - advanced
 Reading _____ Spelling _____ Penmanship _____
 Math _____ Writing _____ Physical Ed _____

- | | |
|---|---|
| <input type="checkbox"/> Does not enjoy reading | <input type="checkbox"/> Eye rubbing |
| <input type="checkbox"/> Eyestrain when reading | <input type="checkbox"/> Errors when copying |
| <input type="checkbox"/> Fatigue with close work | <input type="checkbox"/> Poor writing skills |
| <input type="checkbox"/> Lose place when reading | <input type="checkbox"/> Short attention span |
| <input type="checkbox"/> Poor reading comprehension | <input type="checkbox"/> Sleepy when reading |
| <input type="checkbox"/> Slow reader | <input type="checkbox"/> Words "swim" on page |
| <input type="checkbox"/> Labelled as ADD / ADHD | <input type="checkbox"/> Labelled as Dyslexic |
| <input type="checkbox"/> Special education | <input type="checkbox"/> Reverses words/letters |
| <input type="checkbox"/> Fatigue / daydreams often | <input type="checkbox"/> Prefers being read to |
| <input type="checkbox"/> Teacher has concerns about school performance | |
| <input type="checkbox"/> Hearing, auditory, processing, or speech problem | |

Any of the following therapy: Occupational Speech
 Physical Other _____

Family Medical/Eye History (Check all that apply)

- Is there a family medical history of any of the following:
 Please indicate relationship (IE: Maternal grandmother)
- | | | |
|---------------------------|--------------------------|-------|
| ADD / ADHD | <input type="checkbox"/> | _____ |
| Amblyopia (Lazy eye) | <input type="checkbox"/> | _____ |
| Blindness | <input type="checkbox"/> | _____ |
| Cataracts | <input type="checkbox"/> | _____ |
| Cancer | <input type="checkbox"/> | _____ |
| Corneal disease | <input type="checkbox"/> | _____ |
| Diabetes | <input type="checkbox"/> | _____ |
| Dyslexia | <input type="checkbox"/> | _____ |
| Glaucoma | <input type="checkbox"/> | _____ |
| Heart disease | <input type="checkbox"/> | _____ |
| High blood pressure | <input type="checkbox"/> | _____ |
| Macular degeneration | <input type="checkbox"/> | _____ |
| Retinal disease | <input type="checkbox"/> | _____ |
| Strabismus (eye turn) | <input type="checkbox"/> | _____ |
| Myopia (near sightedness) | <input type="checkbox"/> | _____ |

