VISION REHABILITATION QUESTIONNAIRE

Please fill out this questionnaire carefully. Please return it to our office 1 week prior to your appointment. THANK YOU.

Appointment: Day_____ Date _____ Time _____
Patient's Name: _____

GENERAL INFORMATION
Patient Name: _____ Male ☐ Female ☐
Birth Date: _____ Age: _____
Home Address: _____
Home Phone: _____ Work Phone: _____
How did you hear of our office? _____

MEDICAL HISTORY
Date of injury/accident: _____
Type of injury/accident: Motor vehicle ☐ Fall ☐ Blow to head ☐
Other: _____

WHAT PART OF YOUR HEAD WAS AFFECTED? (check all that apply):
Forehead ☐ Right side ☐ Left side ☐ Back of head ☐ Top of head ☐ Face ☐
Was the injury OPEN HEAD (bleeding) or CLOSED HEAD (non-bleeding)? _____
Did you lose consciousness? Yes ☐ No ☐ If yes, for how long? _____
Were you in a coma? Yes ☐ No ☐ If yes, how long? _____
SYMPTOMS IMMEDIATELY FOLLOWING ACCIDENT/INJURY: (check all that apply)
Double vision ☐ Headache ☐ Blurred vision ☐ Pain in or around eyes ☐ Dizziness ☐
Vomiting ☐ Flashes of light ☐ Disorientation ☐ Loss of balance ☐ Neck pain/whiplash ☐
Loss of memory ☐ Restricted field of view ☐ Restricted motion ☐
Other: _____

INITIAL TREATMENT
When did you first see a doctor regarding your accident/injury? _____
Name of Doctor: _____ Specialty: _____
Where were you seen? _____Were you hospitalized? Yes ☐ No ☐ How long? ___
What were you and your family told? _____
What did the initial treatments consist of? _____
What prognosis/recommendations were you given? _____
Were you given medications? Yes ☐ No ☐ Medication: _____
_____
For what condition(s)? _____

List any medications, including vitamins and supplements used at the current time: _____
_____
Do you have a history of allergies? Yes ☐ No ☐ If yes, please explain:
_____

SUBSEQUENT/OTHER PROFESSIONAL CARE

WHAT TYPES OF PROFESSIONAL CARE HAVE YOU RECEIVED OR ARE YOU CURRENTLY RECEIVING? (check all that apply and describe):

Physicians Name: _____ Date: _____
Results and recommendations: _____

Neurologist Name: _____ Date: _____
Results and recommendations: _____

Neuropsychologist Name: _____ Date: _____
Results and recommendations: _____

Physiotherapist Name: _____ Date: _____
Results and recommendations: _____

Osteopathic Physicians Name: _____ Date: _____
Results and recommendations: _____

Eye Care Practitioner: Name: _____ Date: _____
Results and recommendations: _____

Other / Name: _____ Date: _____
Results and recommendations: _____

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

	Patient	Family	Who		Patient	Family	Who
High blood pressure	☐	☐	_____	Glaucoma	☐	☐	_____
Diabetes	☐	☐	_____	Cataracts	☐	☐	_____
Thyroid condition	☐	☐	_____	Blindness	☐	☐	_____
Multiple Sclerosis	☐	☐	_____	Strabismus	☐	☐	_____
Brain Tumor	☐	☐	_____	Amblyopia	☐	☐	_____
Stroke	☐	☐	_____	Traumatic brain injury	☐	☐	_____

VISUAL HISTORY

Have you had a previous vision evaluation? Yes ☐ No ☐

If yes, doctor's name: _____

Date of last evaluation: _____

Reason for examination: _____

Check off what you use: Glasses ☐ Contact Lenses ☐

If yes, when do you wear the glasses or contacts? Full time? Part-time? For Reading? For Distance Viewing? All the time? _____

Were any additional tests, treatments, or therapies recommended concerning your vision?

Yes ☐ No ☐

If yes, what? _____

Did you undergo these treatments? Yes ☐ No ☐ Explain: _____

Results and recommendations: _____

DO YOU <u>CURRENTLY</u> EXPERIENCE ANY OF THE FOLLOWING:

	Yes	No	Prior to Injury?
Difficulty moving or turning eyes	☐	☐	☐
Pain with movement of eyes	☐	☐	☐
Eyes twitch	☐	☐	☐
Pain in or around eyes	☐	☐	☐
Eye redness	☐	☐	☐
Burning eyes	☐	☐	☐
Watery eyes	☐	☐	☐
Itchy eyes	☐	☐	☐
Double vision	☐	☐	☐
Squinting, covering or closing one eye	☐	☐	☐
Objects jump in and out of field of view	☐	☐	☐
Reduced depth perception	☐	☐	☐
Tunnel vision / Loss of visual field	☐	☐	☐
Flashes of light	☐	☐	☐
Confusion / disorientation	☐	☐	☐
Get lost often	☐	☐	☐
Bothered by noises	☐	☐	☐
Bothered by touch	☐	☐	☐
Difficulty remembering things heard	☐	☐	☐
Difficulty remembering things seen	☐	☐	☐
Difficulty remembering name of objects	☐	☐	☐
Difficulty remembering people's names	☐	☐	☐
Difficulty recalling information known in the past	☐	☐	☐
Difficulty remembering formerly familiar people / objects	☐	☐	☐

Circle a number below:

Please rate each behaviour. how often does each behaviour occur	Never	Seldom	Occasionally	Frequently	Always
Clarity of vision changes or fluctuates during the day	0	1	2	3	4
Eye discomfort / sore eyes / eyestrain	0	1	2	3	4
Headaches or dizziness after using eyes	0	1	2	3	4
Eye fatigue / very tired after using eyes all day	0	1	2	3	4
Feel "pulling' around the eyes	0	1	2	3	4
Print moves in and out of focus when reading	0	1	2	3	4
Normal indoor lighting is bothersome or annoying	0	1	2	3	4
Clumsiness / misjudge where objects really are	0	1	2	3	4
Lack of confidence walking / missing steps / stumbling	0	1	2	3	4
Side vision distorted / objects move or change position	0	1	2	3	4
What looks straight ahead -- isn't always straight ahead	0	1	2	3	4
Avoid crowds / can't tolerate "visually-busy" places	0	1	2	3	4
Short attention span / easily distracted when reading	0	1	2	3	4
Difficulty / slowness with reading	0	1	2	3	4
Difficulty / slowness with writing	0	1	2	3	4
Confusion of words / skip words during reading	0	1	2	3	4
Lose place / have to use finger so don’t lose place reading	0	1	2	3	4
Short Attention span/ easily distracted when reading	0	1	2	3	4

Why do you feel the need for a vision evaluation today? _____

_____

_____

LIFESTYLE

Do you feel your vision interferes with activities of daily living? Yes ☐ No ☐

If yes, please explain (please include effects involving home, work, hobbies social and personal relationships): _____

What activities comprise the majority of your daily life since your accident/injury? _____

What activities can you no longer engage in due to your visual or other difficulties? _____

What other changes/limitations in your daily life do you attribute to your accident/injury? _____

What do you hope a Visual Rehabilitation Program can do for you? What are your goals? _____

THANK YOU FOR CAREFULLY COMPLETING THIS QUESTIONNAIRE

The information supplied will allow for more efficient use of time and will enable us to perform a more comprehensive evaluation related to your specific visual needs.

If you have questions or concerns before your appointment, please give us a call.

We request a minimum 24 hours notice if you are unable to keep this appointment.

Please be on time for your examination, so that we will have the maximum opportunity to evaluate your visual status.

We look forward to meeting you.
Sincerely,

Cynthia Matyas, OD, MSc., FCOVD

The Eye Clinic
1430 King Street East,
Cambridge, ON. N3H 3R4 ph:519-650-2550