# LONG ISLAND OPTOMETRIC VISION DEVELOPMENT, PLLC

**DEVELOPMENTAL OPTOMETRISTS**

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## Vision Evaluation History Form/ADULT

**Appointment Dates/Times:** First Visit:_____ Second Visit:_____ Conference:_____

Patient's First Name:_____ Patient's Last Name:_____
Patient's Nickname: _____ Date of Birth: _____Age:_____
Home Address:_____ City: _____Zip:_____
Patient's Telephone: Home: ( )_____ Cell: ( )_____ Work: _____
Patient's Occupation: _____ Email Address: _____@_____
Social Security#_____

Spouse's First Name:_____ Spouse's Last Name:_____
Spouse's Telephone: Home: ( ) _____Cell: ( ) _____ Work: _____
Spouse's Occupation: _____Email Address: _____@_____
Names and ages of children:
_____ _____
_____ _____

Who may we thank for referring you? _____ Profession: _____
Address: _____ Phone: _____

**ACCOUNT RESPONSIBLE INFORMATION**

Person responsible for payment: Self ( ) Spouse ( ) Other ( )_____

Do You Have **Major Medical** Insurance? Yes ( ) No ( ) Company:_____
Insurance Address:_____ Insurance Phone:_____
Subscriber Name:_____ DOB:_____ SSN:_____
Subscriber ID#:_____ Group#:_____

Do You Have A **Vision** Insurance Plan? Yes ( ) No ( ) Company:_____
Insurance Address:_____ Insurance Phone:_____
Subscriber Name:_____ DOB: _____ SSN:_____
Subscriber ID#:_____ Group #:_____

PLEASE REMEMBER TO BRING ALL INSURANCE CARDS WITH YOU TO YOUR APPOINTMENT.
***Please read and sign the statement below:***
I understand that payment is expected when services are rendered.
I will paying today by: cash_____ check_____ credit card_____

Signature:_____ Date: _____

**VISION HISTORY**

Last Vision Examination Date: _____ Name of Doctor/Address:_____

Recommendations advised at that time: _____

Please check all that apply:

- ☐ I wear glasses only for reading
- ☐ I wear glasses for distance, and remove them for reading
- ☐ I wear glasses full-time
- ☐ I do not use glasses currently for anything
- ☐ I wear contact lenses
- ☐ I use specialized magnifiers/optical devices
- ☐ I use prescription eye drops; please note name of drops and frequency of use: _____
- ☐ I use over-the-counter eye drops; please note name and frequency of use: _____

Has any other professional evaluation found evidence indicating a vision problem is present? ( ) Y ( ) N

If Yes, what? (ie: neurological evaluation, vision exam, occupational therapy evaluation) _____

_____

| Do you experience any of the following symptoms? | No | Yes | If yes, when? |
|---|---|---|---|
| Blurred distance vision | ☐ | ☐ | _____ |
| Blurred vision at near | ☐ | ☐ | _____ |
| Eyestrain or visual fatigue | ☐ | ☐ | _____ |
| Headaches | ☐ | ☐ | _____ |
| Sensitivity to sunlight or bright lights | ☐ | ☐ | _____ |
| Double vision in the distance | ☐ | ☐ | _____ |
| Double vision when reading | ☐ | ☐ | _____ |
| Words split or move on the page | ☐ | ☐ | _____ |
| Eyes hurt | ☐ | ☐ | _____ |
| Eyes feel like they are pulling | ☐ | ☐ | _____ |
| Car sickness/Motion sickness | ☐ | ☐ | _____ |
| Covers or closes one eye when reading | ☐ | ☐ | _____ |
| Loses place along lines when reading | ☐ | ☐ | _____ |
| Moves head when reading | ☐ | ☐ | _____ |
| Eye appears to turn inward/outward | ☐ | ☐ | _____ |
| Reads very slowly | ☐ | ☐ | _____ |
| Frequently blinks or rubs eyes with near work | ☐ | ☐ | _____ |
| Difficulty sustaining attention when reading | ☐ | ☐ | _____ |
| Difficulty understanding reading material | ☐ | ☐ | _____ |
| Avoids reading, used to read a lot more | ☐ | ☐ | _____ |
| Cannot use the computer | ☐ | ☐ | _____ |
| Poor depth judgements with daily tasks | ☐ | ☐ | _____ |
| Poorly organized handwriting | ☐ | ☐ | _____ |
| Clumsy, bumps into things often in environment | ☐ | ☐ | _____ |
| Poor eye-hand coordination | ☐ | ☐ | _____ |
| Difficulty remembering where I put things | ☐ | ☐ | _____ |
| Overwhelmed visually when in supermarket/store shelves | ☐ | ☐ | _____ |
| Difficulty seeing in my peripheral vision | ☐ | ☐ | _____ |
| Difficulty seeing on my right or left side | ☐ | ☐ | _____ |
| Difficulty shifting my focus from near to far | ☐ | ☐ | _____ |
| Perceive movement of stationary objects | ☐ | ☐ | _____ |
| Very hesitant when walking | ☐ | ☐ | _____ |
| Unstable balance/I must have assistance with walking | ☐ | ☐ | _____ |
| Staring behaviors | ☐ | ☐ | _____ |
| Dry or irritated eyes | ☐ | ☐ | _____ |
| Flourescent lights are very bothersome | ☐ | ☐ | _____ |
| Patterned wallpaper or carpet is difficult to look at | ☐ | ☐ | _____ |

| Have you ever had: | No | Yes | When/with whom? |
|---|---|---|---|
| Eye surgery | ☐ | ☐ | _____ |
| Eye patching | ☐ | ☐ | _____ |
| Eye Injury | ☐ | ☐ | _____ |
| Vision therapy | ☐ | ☐ | _____ |

**MEDICAL HEALTH HISTORY**

Please describe any significant current medical concerns: _____

_____

Have you ever had a head injury? No ☐ Yes ☐

If yes, please describe:_____

Do you have/use any of the following?

| | No | Yes | Please describe below |
|---|---|---|---|
| Vitamins/supplements | ☐ | ☐ | _____ |
| Allergies to medications | ☐ | ☐ | _____ |
| Allergies to foods | ☐ | ☐ | _____ |
| Seasonal allergies | ☐ | ☐ | _____ |
| Anxiety/depression/fears | ☐ | ☐ | _____ |
| Emotional concerns in the family | ☐ | ☐ | _____ |
| Medications: (Please list all below) | ☐ | ☐ | _____ |

_____ _____ _____

_____ _____ _____

_____ _____ _____

Internist's Name: _____ Date of Last Visit: _____

Address: _____ Phone: _____

Have you ever been evaluated by the following professionals?

Neurologist ( ) Yes ( ) No

Name: _____ Date of Last Visit: _____

Address: _____ Phone: _____

Results/recommendations given: _____

Psychologist/Neuropsychologist ( ) Yes ( ) No

Name: _____ Date of Last Visit: _____

Address: _____ Phone: _____

Results/recommendations given: _____

Occupational Therapist ( ) Yes ( ) No

Name: _____ Date of Last Visit: _____

Address: _____ Phone: _____

Speech Therapist ( ) Yes ( ) No

Name: _____ Date of Last Visit: _____

Address: _____ Phone: _____

Physical Therapist ( ) Yes ( ) No

Name: _____ Date of Last Visit: _____

Address: _____ Phone: _____

Other ( ) Yes ( ) No

Name: _____ Date of Last Visit: _____

Address: _____ Phone: _____

Have you or a family member ever been treated for any condition relating to:

| | Patient | Family | Whom? | | Patient | Family | Whom? |
|---|---|---|---|---|---|---|---|
| Eyes | ☐ | ☐ | _____ | Neurological | ☐ | ☐ | _____ |
| Ears/Nose/Throat | ☐ | ☐ | _____ | Endocrine | ☐ | ☐ | _____ |
| Cardiovascular | ☐ | ☐ | _____ | Genitourinary | ☐ | ☐ | _____ |
| Respiratory | ☐ | ☐ | _____ | Skin | ☐ | ☐ | _____ |
| Gastrointestinal | ☐ | ☐ | _____ | Musculoskeletal | ☐ | ☐ | _____ |
| Psychiatric | ☐ | ☐ | _____ | Hematologic | ☐ | ☐ | _____ |
| Other | ☐ | ☐ | _____ | | | | |

Do you or family member have any of the following?

| | Patient | Family | Whom? | | Patient | Family | Whom? |
|---|---|---|---|---|---|---|---|
| Diabetes | ☐ | ☐ | _____ | Glaucoma | ☐ | ☐ | _____ |
| High Blood Pressure | ☐ | ☐ | _____ | Macula Degeneration | ☐ | ☐ | _____ |
| Thyroid Disease | ☐ | ☐ | _____ | Cataracts | ☐ | ☐ | _____ |
| Multiple Sclerosis | ☐ | ☐ | _____ | Crossed or wall eyes | ☐ | ☐ | _____ |
| Genetic Abnormalities | ☐ | ☐ | _____ | Amblyopia (lazy eye) | ☐ | ☐ | _____ |
| Epilepsy or Seizures | ☐ | ☐ | _____ | Dyslexia | ☐ | ☐ | _____ |
| Cancer | ☐ | ☐ | _____ | Learning Disability | ☐ | ☐ | _____ |

What services are you <u>currently</u> receiving? Please check all that apply:

| | | | | | |
|---|---|---|---|---|---|
| Occupational Therapy: | No | ☐ | Yes | ☐ | No. times per week: _____ |
| Physical Therapy: | No | ☐ | Yes | ☐ | No. times per week: _____ |
| Speech Therapy: | No | ☐ | Yes | ☐ | No. times per week: _____ |
| Cognitive Therapy: | No | ☐ | Yes | ☐ | No. times per week: _____ |
| \ Counseling: | No | ☐ | Yes | ☐ | No. times per week: _____ |

Other: Please describe: _____

| **LIFESTYLE / SOCIAL HISTORY** | No | Yes | |
|---|---|---|---|
| Are you currently working? | ☐ | ☐ | How often?_____ |
| Are you currently a student? | ☐ | ☐ | Where? _____ |
| Do you smoke? | ☐ | ☐ | How often? _____ |
| Do you drink alcohol? | ☐ | ☐ | How often? _____ |
| Do you exercise? | ☐ | ☐ | How often? _____ |

Is there anything else you would like to comment on regarding your current vision or general health?

_____

_____

**FINANCIAL POLICY:**

If we are participating providers with your insurance company, we will bill them directly. If we are not, we require payment at the time of the visit and we will provide you with a receipt for reimbursement submission. Any copayments are required at the time of service.

We are participating providers with: Blue Cross Blue Shield, Aetna US Healthcare and Medicare. By signing below you authorize the release of any medical information to process your insurance claims. You also allow your payment from insurance to be sent directly to Long Island Optometric Vision Development, PLLC.

Please sign that you understand the above:

Signed: _____ Date: _____

# Quality of Life Symptom Checklist

Today's Date: _____ Person Filling out form: _____
Patient Name: _____ Date of Birth: __/__/___

**Please circle how often each symptom occurs based on the given scale:**

0 = Never or Non-existent
1= Seldom
2= Occasionally
3= Frequently
4= Always

| | | |
|---|---|---|
| 1 | Experiences blurred vision at near | 0 1 2 3 4 |
| 2 | Experiences double vision at distance | 0 1 2 3 4 |
| 3 | Experiences double vision at near | 0 1 2 3 4 |
| 4 | Words run together when reading | 0 1 2 3 4 |
| 5 | Burning, stinging, watery eyes or rubs eyes often | 0 1 2 3 4 |
| 6 | Falls asleep when reading or loses interest easily when reading | 0 1 2 3 4 |
| 7 | Note that vision is worse at the end of the day | 0 1 2 3 4 |
| 8 | Skips or repeats lines when reading, loses place | 0 1 2 3 4 |
| 9 | Dizziness or nausea associated with near work | 0 1 2 3 4 |
| 10 | Tilts head or closes one eye when reading | 0 1 2 3 4 |
| 11 | Experiences headaches associated with near work or end of day | 0 1 2 3 4 |
| 12 | Experiences eyestrain and eye fatigue with reading or computers | 0 1 2 3 4 |
| 13 | Omits small words when reading | 0 1 2 3 4 |
| 14 | Writes uphill, downhill, or off- line; poorly organized writing | 0 1 2 3 4 |

| | | |
|---|---|---|
| 15 | Mis-aligns digits in columns of numbers | 0 1 2 3 4 |
| 16 | Reading comprehension is poor or declines over time | 0 1 2 3 4 |
| 17 | Difficulty concentrating when reading | 0 1 2 3 4 |
| 18 | Poor balance or dizziness when walking | 0 1 2 3 4 |
| 19 | Poor depth judgements | 0 1 2 3 4 |
| 20 | Poor eye-hand coordination | 0 1 2 3 4 |
| 21 | Tendency to knock things over on desk or table; appears clumsy | 0 1 2 3 4 |
| 22 | I must hold on to someone or use a cane when walking | 0 1 2 3 4 |
| 23 | Difficulty remembering where I put things | 0 1 2 3 4 |
| 24 | Difficulty finding things on a shelf, in refrigerator, etc. | 0 1 2 3 4 |
| 25 | Difficulty seeing on my right side or left side | 0 1 2 3 4 |
| 26 | Difficulty remembering what I read | 0 1 2 3 4 |
| 27 | Avoids reading | 0 1 2 3 4 |
| 28 | Avoids writing | 0 1 2 3 4 |
| 29 | Car sickness / motion sickness | 0 1 2 3 4 |
| 30 | Difficulty with time management | 0 1 2 3 4 |