Eye Priority RE-Vision
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ADULT VISION QUESTIONNAIRE

Thank you for carefully completing the questionnaire. Please bring it to our office at your appointment time.

Patient's Name _____ DOB _____ Age _____

Who may we thank for referring you to our office? _____

Preferred Gender: Man/Male Woman/Female Non-Binary Prefer Not to Say

Preferred Pronouns: She/Her/Hers He/Him/His They/Them/Theirs Ze/Zir/Zirs

Marital Status: Single Married Divorced Widowed

Address _____ City _____ State _____ Zip _____

Primary Phone Number _____ Email _____

Preferred Method of Contact: Phone Email Text

Occupation _____ Employer _____

Spouse Name _____ Occupation _____

Other Family Members' Names and Ages _____

_____

Visual History

What is the reason for today's visit? _____

_____

_____

When did these symptoms first begin? _____

Has the problem become better or worse? Please explain _____

_____

Have you had a previous vision evaluation? Yes No

If yes, doctor's name _____ Date of Evaluation _____

Reason for examination _____

Were glasses, contact lenses, or other optical devices recommended? Yes No

If yes, what? _____

Are they used? Yes No If yes, when? _____

If no, why not? _____

Were any additional tests, treatments, or therapies recommended concerning your vision? Yes No

If yes, what? _____

Did you undergo these treatments? Yes No Please explain _____

Results and recommendations _____

Visual Symptom Checklist

- ☐ Headaches
- ☐ Blurred vision at distance
- ☐ Blurred vision at near
- ☐ Double vision at distance
- ☐ Double vision at near
- ☐ Halos around lights
- ☐ Nausea associated with visual tasks
- ☐ Need for very bright light for near tasks
- ☐ Need for very dim light for near tasks
- ☐ Eyes hurt or burn
- ☐ Eyes feel tired
- ☐ Words appear to move or float on the page
- ☐ Motion sickness/car sickness
- ☐ Dizziness
- ☐ Red or itchy eyes
- ☐ Watery eyes
- ☐ Frequent eye rubbing
- ☐ Frequent sties
- ☐ Frequent blinking
- ☐ Closing or covering one eye/squinting
- ☐ Postural changes when doing desk work
- ☐ Head close to paper when reading/writing
- ☐ Avoids reading or other near tasks
- ☐ Tilts head when reading or near tasks
- ☐ Moves head when reading
- ☐ Can respond better orally than in writing
- ☐ Reverses letters or words
- ☐ Confuses right and left
- ☐ Skips, rereads, or omits words
- ☐ Loss of place when reading
- ☐ Skips lines when reading
- ☐ Vocalizes when reading silently
- ☐ Reads slowly
- ☐ Use of finger or object to keep place
- ☐ Poor reading comprehension
- ☐ Comprehension decreases over time
- ☐ Tires easily/visual fatigue
- ☐ Difficulty switching focus from near to far
- ☐ Difficulty sustaining reading or near tasks
- ☐ Falling asleep when reading
- ☐ Remembers better orally than by writing
- ☐ Difficulty aligning columns of numbers
- ☐ Poor time management
- ☐ Short attention span/loses interest
- ☐ Poor general motor coordination
- ☐ Poor fine motor coordination
- ☐ Difficulty with scissors/small hand tools
- ☐ Inconsistent performance in work or sports
- ☐ Difficulty with long-term memory
- ☐ Difficulty with short-term memory

Do you feel your vision hinders your daily activities in any way? Yes No

If yes, how? _____

_____

_____

Eye Irregularities

Does one pupil ever appear to be larger than the other? Yes No

Do you ever notice one or both eyes shaking rapidly? Yes No

Have you ever been told that you have amblyopia (lazy eye)? Yes No

Have you noticed any eye turn? Yes No (If no, skip to the next section)

When did you first notice or suspect eye turn? _____

Did the eye begin turning: Suddenly Gradually

Does the eye turn: In Out Up Down

Is the eye turn getting worse or better, or is there no change? _____

Is it always the same eye that turns? Yes No Which Eye? Right Left

Is the eye turn always present? Yes No

If not, under what conditions is it present (i.e., when tired, when ill, etc.)? _____

_____

Is the eye turn noticed more if you are looking:

Up close	Yes	No	To your right	Yes	No
In distance	Yes	No	Up	Yes	No
To your left	Yes	No	Down	Yes	No

Does the eye turn less when the prescription is worn? Yes No

Has there been any treatment using an eye patch? Yes No

If yes, please describe when the patching was started and how patching was done (include the age it started, the eye patched, the duration of treatment, and an estimate of the results) _____

_____

_____

Has there been any surgical treatment? Yes No

If yes, describe the surgery (include the age surgery was performed, the number of operations, the eye operated on, and an estimate of the cosmetic and subjective results) _____

_____

Were you satisfied with the results of the surgery? Yes No

Please explain _____

_____

Was the surgeon satisfied with the results of the surgery? Yes No

Please explain _____

_____

Medical History

Do **you** have any of the following:

- ☐ Autism
- ☐ Brain tumor
- ☐ Cancer Type: _____
- ☐ Diabetes
- ☐ Heart condition
- ☐ High blood pressure
- ☐ Mental illness Type _____
- ☐ Multiple sclerosis
- ☐ Stroke
- ☐ Surgeries Type: _____
- ☐ Thyroid conditions
- ☐ Amblyopia
- ☐ Blindness
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Keratoconus
- ☐ Macular degeneration
- ☐ Strabismus
- ☐ Turned or “lazy” eye
- ☐ Vision-related learning disability

Does **anyone in your immediate family** (parents, siblings, children, grandparents-note if maternal or paternal) have any of the following:

- ☐ Autism Who? _____
- ☐ Brain tumor Who? _____
- ☐ Cancer Who? _____
  Type: _____
- ☐ Diabetes Who? _____
- ☐ Heart condition Who? _____
- ☐ High blood pressure Who? _____
- ☐ Mental illness Who? _____
  Type: _____
- ☐ Multiple sclerosis Who? _____
- ☐ Stroke Who? _____
- ☐ Thyroid conditions Who? _____
- ☐ Amblyopia Who? _____
- ☐ Blindness Who? _____
- ☐ Cataracts Who? _____
- ☐ Glaucoma Who? _____
- ☐ Keratoconus Who? _____
- ☐ Macular degeneration Who? _____
- ☐ Strabismus Who? _____
- ☐ Turned or “lazy” eye Who? _____
- ☐ Vision-related learning disability
  Who? _____

Physician’s name _____ Date of most recent evaluation _____

For what problem/condition? _____

Results and recommendations _____

Your current state of health Excellent Good Fair Poor

Medications

Please list all medications you are currently taking (continue on back of page or attach a separate sheet if needed):

Medication Name	Reason for Taking	Dose	Frequency

Vitamins and Supplements

Please list all vitamins and/or supplements you are currently taking (continue on back of page or attach a separate list if needed):

Vitamin/Supplement Name	Reason for Taking	Frequency

Do you have any allergies? Yes No

If yes, please explain _____

Current diet: Excellent Good Fair Poor

Do you smoke or vape? Yes No

Do you drink alcohol? Yes No How much? _____

Do you use illegal substances or recreational drugs? Yes No

If yes, type: _____ Frequency of use: _____

Current state of health (explain) _____

Sports

Are you seriously involved with athletics? Yes No

Do you feel you are performing up to your potential in sports/athletics? Yes No

Of all the sports you have played, list the ones in which you:

Excel _____

Avoid or do poorly _____

Hobbies/Leisure Time

Describe the types of activities that comprise the majority of your leisure time _____

_____

_____

_____

Screen Time

Do you:

- Watch television shows, movies, or YouTube videos? Yes No
  How do you watch (circle all that apply): Television iPad/Tablet Cell Phone Computer/Laptop
- Play video games? Yes No
  How do you play (circle all that apply): Television iPad/Tablet Cell Phone Computer/Laptop
- Engage in social media? Yes No
  How do you engage (circle all that apply): iPad/Tablet Cell Phone Computer/Laptop

How many days per week do you spend on these activities? _____

How many hours per day do you spend on these activities? _____

How do your eyes feel after engaging in these activities? _____

If you use a television or a computer/laptop for leisure activities:

- What is the size of the screen? _____
- Distance from the screen? _____

Computers

Do you use a computer for work or school? Work School Both

What type(s) of computer work do you perform (select all that apply)?

- Word processing
- Programming or coding
- Data entry
- Email
- Internet browsing
- Other (explain) _____

What type of computer do you use for work and/or school? Desktop Laptop

What is the size of the monitor? _____

What is the distance from:

- Your eyes to the screen _____
- Your eyes to the keyboard _____
- Your eyes to your source documents _____

Where is the top of the screen located (select one)?

- Above eye level
- At eye level
- Below eye level

Where is the computer screen located when you are seated (select one)?

- Directly in front of you
- To your right
- To your left

Where are your source documents located?

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

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 (explain) _____

How many hours do you spend in front of a computer screen for work and/or school each day? _____

How do your eyes feel after working at the computer? _____

Driving

Do you currently drive? Yes No

If no, would you like to return to driving? Yes No

Do you have any issues driving? Yes No

If yes, what type(s) of issues do you experience?

- ☐ Decreased reaction time
- ☐ Issues with focusing on the road while car is in motion
- ☐ Distracted by objects in periphery while car is in motion (other cars, etc.)
- ☐ Double or blurred vision
- ☐ Motion sickness
- ☐ Issues with driving at night

Employment/School

Current position _____

Are you currently a student? Yes No If yes, major course of study _____

How many hours a day do you spend at a desk? _____

How many hours a day do you spend reading or studying? _____

How many hours a day do you spend working at near distances? _____

Do you feel you are performing up 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 of written documents or books? Yes No

Briefly describe your daily activities at work or school _____

_____

Is there any other information you feel would be helpful/important as we treat you? _____

_____

_____

_____

_____

_____

Form completed by: _____

Name **Relationship to Patient**

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RECORDS RELEASE/REQUEST

TO: _____

(Doctor/Hospital/School)

ADDRESS: _____

CITY: _____ **State:** _____ **Zip** _____

I hereby authorize the release of my copied medical records. I request that they be transferred to:

Eye Priority RE-Vision
15725 S 46th Street, Suite 112
Phoenix, AZ 85048
Phone: 480-893-3999
Fax: 480-297-0503
Email: vtinfo@eyepriority.com

_____
Print Name of Patient

From: _____ **To:** _____
Date of Records Requested

_____ **Date:** _____
Signature of Patient/Parent/Guardian

This authorization shall be considered valid for 12 months from the date signed.