Eye Priority RE-Vision
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ACQUIRED BRAIN INJURY 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 _____

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING:

Please check if this was a problem prior to injury?

- ☐ Eyes ache _____
- ☐ Eyes pull or tug _____
- ☐ Difficulty moving or turning eyes _____
- ☐ Pain with movement of eyes _____
- ☐ Eyes twitch _____
- ☐ Eye redness _____
- ☐ Burning, itchy or watery eyes _____
- ☐ Bothered by brightness/bright lights _____
- ☐ Bothered by noises _____
- ☐ Bothered by touch _____
- ☐ Motion sickness / car sickness _____
- ☐ Headaches _____
- ☐ Blurred vision _____
- ☐ Difficulty changing focus far to near _____

- ☐ Double vision _____
- ☐ One eye turns in, out, up or down _____
- ☐ Movement of objects in the environment is bothersome _____
- ☐ Fluorescent light is bothersome _____
- ☐ Patterned wallpaper or carpets are bothersome _____
- ☐ Head moves when reading _____
- ☐ Lose place often when reading _____
- ☐ Words jump or move around when reading _____
- ☐ Short attention span for reading or writing _____
- ☐ Skip words frequently when reading _____
- ☐ Discomfort when reading _____
- ☐ Loss of interest/concentration when doing close work _____
- ☐ Orient writing/drawing poorly on page _____
- ☐ Squinting, covering or closing one eye _____
- ☐ Head tilts during desk work _____
- ☐ Hold books too close _____
- ☐ Avoid reading or writing _____
- ☐ Difficulty with peripheral vision _____
- ☐ Objects jump in and out of field of view _____
- ☐ Reduced depth perception _____
- ☐ Tunnel vision / loss of visual field _____
- ☐ Flashes of light _____
- ☐ Difficulty with dressing _____
- ☐ Difficulty with bathing / personal hygiene _____
- ☐ Difficulty following a series of directions _____
- ☐ Difficulty using both sides of the body together _____

- ☐ Dislike heights _____
- ☐ Awkward, poor balance _____
- ☐ Dizziness _____
- ☐ 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 _____
- ☐ Difficulty performing tasks formerly easy/routine _____
- ☐ Difficulty with time management _____
- ☐ Difficulty with numbers _____
- ☐ Difficulty counting money _____

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

If yes, how? _____

_____

_____

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? _____

Date of injury/accident/onset _____

Type of injury/accident:

- ☐ Blow to head
- ☐ Carbon dioxide
- ☐ Cord around neck
- ☐ Drowning
- ☐ Drug abuse
- ☐ Fall
- ☐ Hemorrhage
- ☐ Industrial Accident
- ☐ Medication-related
- ☐ Motor vehicle
- ☐ Poison or toxic substance
- ☐ Stroke Aneurysm
- ☐ Other _____

What part of your head was affected? (circle 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, for how long? _____

SYMPTOMS IMMEDIATELY FOLLOWING ACCIDENT/INJURY:

- ☐ Blurred vision
- ☐ Disorientation
- ☐ Dizziness
- ☐ Double vision
- ☐ Flashes of light
- ☐ Headache
- ☐ Loss of balance
- ☐ Other _____
- ☐ Loss of memory
- ☐ Neck pain/whiplash
- ☐ Pain in or around eyes
- ☐ Restricted field of view
- ☐ Restricted motion
- ☐ Vomiting

Initial Treatment

When did you first see a doctor regarding your accident/injury? _____

Name of doctor _____ Specialty _____

Where were you seen? Hospital Doctor's Office Urgent Care Other _____

Were you hospitalized? Yes No If yes, 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 List Medications _____

For what condition(s)? _____

_____

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

Subsequent or Other Professional Care

What types of professional care have you received or are you currently receiving? (Complete all that apply)

Has a neurological evaluation been performed? Yes No

If yes, by whom _____ Date _____

Results _____

Has a psychological evaluation been performed? Yes No

If yes, by whom? _____ Date _____

Results _____

Has a speech and language evaluation been performed? Yes No

If yes, by whom? _____ Date _____

Results _____

Has a neuropsychological evaluation been performed? Yes No

If yes, by whom? _____ Date _____

Results _____

Has an osteopathic evaluation been performed? Yes No

If yes, by whom? _____ Date _____

Results _____

Has a physical therapy evaluation been performed? Yes No

If yes, by whom? _____ Date _____

Results _____

Has an occupational therapy evaluation been performed? Yes No

If yes, by whom? _____ Date _____

Results _____

Have any other evaluations been performed? Yes No

If yes, what other evaluations were performed? _____

By whom? _____ Date _____

Results _____

Do you have a history of allergies? Yes No

If yes, please 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 _____

_____

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? _____

_____

_____

_____

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.