ADULT HISTORY FORM

Name____ Birthday _____/_____/______ Age ____yr ___ mo

Education: ____________________________________ Occupation ______________________ Phone _______________

Occupation ___________________________________ Phone _____________ Fax: ____________ email: ___________

Mailing Address ____

Who referred you to this clinic? ______________________________ Relationship to referral source: _________________

I. Please state the major reason you would like to be examined in our Binocular Vision clinic: _________

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II. Symptoms:

Vision:	**Yes**	**No**	**Persistent Symptoms:**	**Yes**	**No**
Period of vision loss			Headaches		
Blurred distance vision			Dizziness/lightheadedness		
Blurred reading vision			Seizures		
Eyes hurt			Clumsiness, dropping things, weak grasp		
Eyes tire			Changes in hearing		
Lazy eye/amblyopia			Ringing in your ears		
Double vision			Changes in taste		
Eye turn (crossed or wall-eyed)			Changes in smell		
Covers one eye at close work			Sensitivity to noise/smell/light		
Seing multiple images			Numbness/tingling		
Eyes “wobble”(nystagmus)			Difficulties walking		
Blinks excessively			Loss of balance		
Difficulties at computer station			Frequent pain anywhere		
Difficulties seeing/looking sideways					
Holds books closer than normal					

III. Eye Care and Diagnostic Evaluations:

Eye Care :	**Yes**	**No**	**Other Examinations**	**Yes**	**No**
Wears glasses			Recent eye exam		
Wears contact lenses			Neurological exam		
Eye turn as a child			Neuro-ophthalmological exam		
Patch/eye therapy as a child			MRI		
Previous eye surgery			CT scan		
Other visual problems			Skull X-ray		
			EEG		

III. General Health and Medical History (Personal and Family):

Your Medical History	**Yes**	**No**	**Family Medical History**	**Yes**	**No**
Head Trauma					
Concussion					
Loss of consciousness					
Automobile Accident					
Physical impairment as a child			Heart Disease and/or Hypertension		
Seizures or high fevers as a child/adult			Diabetes		
Allergies and/or asthma as a child/adult			Cancer		
Heart Disease, Hypertension, Stroke			Migraine		
Diabetes			Neurological/Psychological Disorders		
Cancer			Learning Disabilities		
Medications*, **please list on line below**					

Current Medication*:____

____

Over →

IV. Previous and Current Rehabilitation Therapy:

Rehabilitation therapy:	Yes	No	Type of therapy, duration and results
Physical Therapy			
Occupational Therapy			
Speech and Language			
Neuro-psychology			
Rehabilitation Counseling			
Visual Therapy			

V. What specific type(s) of activities do you enjoy or wish to resume? ______________________________

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VI. Education and Cognition: (PLEASE RESPOND TO THE FOLLWING QUESTIONS, IF YOU HAVE BEEN DIAGNOSED WITH LEARNING DISABILITIES, HEAD TRAUMA OR STROKE)

School performance as a child	Yes	No	Present cognitive challenges as an adult	Yes	No
Did you have difficulties in school?			Changes in Short term memory		
Were you satisfied with your performance?			Changes in Long term memory		
Did your grades really show your ability?			Difficulties understanding what is said to you		
Did you have trouble completing written assignments?			Difficulties expressing your thoughts in writing		
Did you lose your place while reading?			Frequently losing your place when reading		
Did you misread known words?			Difficulties understanding what you read		
Did you have difficulties with reading comprehension			Difficulties with arithmetic or balancing checkbook		
Early diagnosis of learning disability					

VII. Behaviors: (PLEASE RESPOND TO THE FOLLWING QUESTIONS, IF YOU HAVE BEEN DIAGNOSED WITH LEARNING DISABILITIES, HEAD TRAUMA OR STROKE)

Please try to rate your behaviors at work or home. Place a number in the blank space to the left of the item that best describes the frequency of your behavior.

1—Always 2—Frequently 3—Occasionally 4—Rarely 5—Never 6—Unknown

	Hyperactive		Poor ability to organize work		Difficulties following a series of verbal instructions or directions
	Easily Distracted		Changes in sleep pattern		Variable performance (from hour to hour/day to day)
	Short attention span		Feel awkward or clumsy		Reverses letters, words or numbers in reading/writing
	Easily frustrated		Poor peer group relationships		Confusion about right or left
	Impulsive		Irritable or short-tempered		Given up hobbies/interests
	Easily fatigued		Depressed mood		Difficulties initiating or completing chores/tasks

.**Signature:** ____ **Date:** ____________________

Other person filling out this form: ____________________________**Relationship to patient:** ____________

Comments:

Thank you