

Lynn H. Trieu, OD, MS

Fellow, American Academy of Optometry
Fellow, College of Optometrists in Vision Development

True Vision Therapy, LLC

Pediatric Eye Care and Vision Therapy
Neuro-Optometry and Rehabilitation

Questionnaire for Adult and Brain Injury Patients

Name _____ F M _____ DOB _____ Age _____ Today's Date _____

Address _____ City _____

State _____ Zip _____ Home Phone _____ Cell Phone _____

Email _____ Occupation _____ Referred by _____

Fill Out If Patient is a Minor

Parents' Names: Parent 1: _____ Parent 2: _____

Occupations: Parent 1: _____ Parent 2: _____ Marital Status: Married Single Divorced

Patient's Previous Diagnosis: _____ Adopted: Yes No

Reason for today's visit (include any visual symptoms you are experiencing):

When did the problem(s) start?

Did you suffer from an accident, brain injury, or stroke? Yes No If yes, please describe how it occurred.

Have you seen any other professionals regarding this problem? Yes No If yes, please list the names of the professionals and describe findings.

Visual History

When was your last eye examination?

Who is your primary eye doctor? Name:

Address:

Phone:

Are you being followed by any other eye doctors regarding your eyes or vision?

Please describe any previous eye or vision problems and visual treatment you have received (including glasses, vision therapy, patching, surgery, or medications).

Please check any of the following symptoms that apply to you:

- | | | |
|--|---|---|
| <input type="checkbox"/> blurred distance vision | <input type="checkbox"/> squint or blink excessively | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> blurred vision during reading | <input type="checkbox"/> rub eyes during reading | <input type="checkbox"/> motion sickness |
| <input type="checkbox"/> double vision | <input type="checkbox"/> skip or reread words and lines | <input type="checkbox"/> loss of balance |
| <input type="checkbox"/> fatigue during near visual tasks | <input type="checkbox"/> loss of place when reading | <input type="checkbox"/> loss of memory |
| <input type="checkbox"/> words moving or running together | <input type="checkbox"/> head movement when reading | <input type="checkbox"/> restricted eye motion |
| <input type="checkbox"/> eye strain or pain | <input type="checkbox"/> use finger or underliner to read | <input type="checkbox"/> restricted field of view |
| <input type="checkbox"/> frequent headaches | <input type="checkbox"/> red or teary eyes | <input type="checkbox"/> disorientation |
| <input type="checkbox"/> eyes cross or drift in/out or up/down | <input type="checkbox"/> avoid near work | <input type="checkbox"/> poor night vision |
| <input type="checkbox"/> close one eye when reading | <input type="checkbox"/> poor depth perception | <input type="checkbox"/> light sensitivity |
| <input type="checkbox"/> hold reading material too close | <input type="checkbox"/> poor eye-hand coordination | <input type="checkbox"/> other (please describe) |
| <input type="checkbox"/> turn or tilt head | <input type="checkbox"/> do not enjoy sports | |

Medical History

When was your last physical examination or doctor's visit?

Who is your primary care provider? Name:

Address:

Phone:

Do you suffer from any health problems, including any allergies or asthma? Yes No If yes, please describe.

Have you had any severe illnesses, injuries, or hospitalization? Yes No If yes, please describe.

Are you taking any medications? Yes No If yes, please list:

Are you being followed by any other health care professionals? If yes, please list their names and reason for care.

Family History

Does anyone in the family have any of the following?

- strabismus (crossed eyes or drifting eyes)
- amblyopia (lazy eye)
- high nearsightedness, farsightedness, or astigmatism
- learning or reading problems
- blindness
- eye disease (please describe)

Relationship to You

Thank you for carefully completing this questionnaire.
