the eyeclinic
Doctors + Vision Therapy

1430 King Street E.
Cambridge, ON
N3H 3R4
t. 519 650 2550
f. 519 650 3720
theeyeclinic.ca

Adult Patient Information

Name: _____ Birth date: _____ _____ _____
M D Year

Address:_____
_____
_____

Phone (day):_____

Would you prefer email correspondence? If so, email address _____

Who Referred you to The Eye Clinic? _____

If you have questions or concerns before your appointment, please give us a call.

We request a minimum 48 hours notice if you are unable to keep this appointment.

Please be on time for your examination, so that we will have the maximum opportunity to evaluate your visual status.

Payment is by visa, mastercard, or debit.

Patient History Questionnaire- Adult

Please fill out the questionnaire carefully and return it to the office 1 week prior to your appointment. The time spent answering the questions will allow the doctor to better plan the flow of the examination procedures.
Thank you for your time and effort in completing this questionnaire. Leave blank or put "N/A" beside questions that do not apply.

PRESENT SITUATION AND SYMPTOMS

What are the concerns that prompted this vision skills evaluation?

_____

_____

_____

_____

How long have these concerns been observed?_____
What goal(s) do you hope to accomplish from the vision skills evaluation?

_____

_____

VISUAL HISTORY

Last Vision evaluation (year) _____Doctor:_____City:_____
Were glasses, contact lenses, or other optical devices prescribed or recommended?
____yes_____no. If so, what_____ Do you use them? ____yes ____no.
How long have you used them?_____
If used, when?_____ If not, why not?

_____
Explain any history of eye surgeries, eye/head injuries, vision therapy or other treatments in the past

_____
_____
_____
_____
_____

If you experience any of the following, please write the number that best describes how often they occur:

1-always 2- a lot 3- sometimes

___ skips, inserts or re-reads words
____ loses place while reading
___ omits small words when reading
___ mistakes words with similar beginnings and endings
___ uses finger as a marker
____ moves head when reading
___ head close to page when reading

____ reads slowly

___ reduced efficiency /productivity
___ headaches during/after reading
____blurred distance vision
____ blurred reading vision
____ eyes hurt
____ eyes tire
___ poor reading comprehension
___ comprehension decreases with time
___ frequent blinking during reading
___ frowns, scowls or squints to see
____ avoids/ dislikes near tasks ie. reading
____ fatigues easily during visual tasks
___ rubs eyes during/after visual activity
___ inaccurate/ inconsistent visual attention
___ vision worse at end of day
___ falls asleep when reading
____ double vision
___ words move around the page
___ tilts head during desk work
___ closes or covers one eye
___ one eye turns in, out, up or down

___ difficulty copying from board
___ confuses similar words
___ fails to recognize same word on next page
___difficulty following verbal instructions
___ says words aloud or moves lips as reads
___ short attention span/loses interest
____poor printing or handwriting
___ responds better verbally than by writing
___ writes neatly but slowly
____reverses letters, words or numbers
___ confuses left and right
___ tends to knock things over on desk or table
___ poor recall of visually presented tasks
____school performance not up to potential
____nausea associated with visual tasks
___ motion sickness/car sickness
____easily frustrated
____light sensitivity
____variable school performance
___ difficulty aligning number columns
___ seems to know material, but does poorly on tests
___ bumps into people/objects
___ forgetful, poor memory
___ behaviour problems
___ poor ability to organize work
___ needs very bright light when reading
___ needs very dim light when reading

Any other symptom/concerns not mentioned on the previous checklist?

_____
_____
_____
_____
_____

COMPUTERS

Do you use computers in your work, school, or leisure time activities?_____yes_____no If so, indicate the types of computer work you perform:

____ Word processing
____ Programming
____ Data Entry
____ Internet
____ Games
____ Other (explain):_____

How many hours do you spend in front of a computer screen a day?_____
How do your eyes feel after working at the computer?_____

Where is the top of the screen located?

____ Above your straight- ahead eye level
____ At eye level
____ Below eye level

What is the distance from: Your eyes to the screen?_____

HOBBIES/SPORTS

Describe the activities that comprise the majority of your leisure time:_____
_____
Do you watch TV? ____yes_____no If yes, how many hours per week?_____
Are you involved with athletics?_____yes_____no
List the sports in which you participate:_____
Are there any activities/sports you would like to participate in but don't? If so, please explain_____
_____

EMPLOYMENT OR SCHOOL

Current Position:_____ or Major course of study:_____

How many hours a day do you spend sitting 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 achieving 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
Describe briefly your daily activities at work in school:_____
_____

MEDICAL HISTORY

Current State of Health:_____
Medications:_____ Allergies:_____
Have you ever had a concussion?_____yes_____no. If yes, give
details_____
Have you ever had whiplash ? _____yes _____no. If yes, give
details_____

Is there any history of the following? Please check the appropriate box(es):

	Patient	Family	Who		Patient	Family	Who
Diabetes	□	□	_____	Strabismus/crossed eye	□	□	_____
Multiple Sclerosis	□	□	_____	Amblyopia/lazy eye	□	□	_____
Blindness	□	□	_____	Thyroid Condition	□	□	_____
Glaucoma	□	□	_____	Cataracts	□	□	_____
Hypertension	□	□	_____	Brain Tumor	□	□	_____

THANK YOU FOR CAREFULLY COMPLETING THIS QUESTIONNIARE.

The information supplied will allow for more efficient use of time and will enable us to perform a more comprehensive evaluation related to your specific visual needs.

If you have questions or concerns before your appointment, please give us a call.

We request a minimum 48 hours notice if you are unable to keep this appointment.

Please be on time for your examination, so that we will have the maximum opportunity to evaluate your visual status.

We look forward to meeting you.

Sincerely,

Cynthia Matyas, OD, MSc, FCOVD