IN SIGHT VISION THERAPY

PATIENT INFORMATION FORM

Thank you for coming to our office! How did you hear about us? _____ Today's Date: _____

Patient's Name: _____ Date of Birth: _____

Address: _____ Phone Number: (_____) _____

Parent/Guardian Name(s): _____ Relationship to Patient: _____

Patient's occupation / school: _____ Patient's employer / Grade: _____

Hobbies: _____ Your email: _____

Names and ages of immediate family: _____

OCULAR HISTORY

Are you interested in any of the following? ☐ Glasses ☐ Contacts ☐ LASIK ☐ Vision Therapy

Last eye exam : _____ Previous doctor/clinic : _____

Do you have glasses? ☐ Yes ☐ No If yes, when are they used? ☐ Distance ☐ Near ☐ Both

Do you have contacts? ☐ Yes ☐ No If yes, what brand (if known)? _____

Do you ***currently*** have any **vision-related issues**?

☐ Blurred vision ☐ Double vision
☐ Loss of vision ☐ Flashes in vision
☐ Floaters in vision ☐ Blind spots
☐ Eye turn ☐ Lazy eye
☐ Halos in vision ☐ Light sensitivity
☐ Head tilt / face turn ☐ Lose attention easily
☐ Motion sickness/ carsickness
☐ Discomfort with 3-D movies
☐ Poor reading comprehension
☐ Poor tracking / eye movements
☐ Other (explain): _____

Do you ***currently*** have any **eye comfort-related issues**?

☐ Dry eyes ☐ Burning eyes ☐ Red eyes
☐ Tired eyes ☐ Eye pain ☐ Eye soreness
☐ Watery eyes ☐ Mucous discharge ☐ Itchy eyes
☐ Gritty/sandy feeling
☐ Other (explain): _____

Do you ***currently*** have any **motor-related issues**?

☐ Poor motor control ☐ Clumsy / stumble easily
☐ Trouble catching a ball
☐ Other (explain): _____

Do you ***currently*** have any **eye diseases**?

☐ Cataracts ☐ Glaucoma ☐ Styes
☐ Keratoconus ☐ Macular degeneration
☐ Other (explain): _____

Describe any eye injuries: _____

List any eye surgeries: _____

List any eye drops used: _____ How often used? _____

CURRENT MEDICAL INFORMATION: **CHECK** Yes / No and **CIRCLE** or describe any issues that apply.	**Yes**	**No**
Fever, weight loss/gain, other general problems : _____	☐	☐
Ear, nose, throat problems (sinus, ear infection, chronic cough, dry mouth, etc.): _____	☐	☐
Cardiac / Vascular problems (high blood pressure, heart pain, vascular disease, etc.): _____	☐	☐
Respiratory problems (asthma, emphysema, use of CPAP machine etc.): _____	☐	☐
Gastrointestinal problems (stomach ulcers, reflux, etc.): _____	☐	☐
Genital, kidney or bladder problems: _____	☐	☐
Muscle, bone or joint problems (arthritis, etc.): _____	☐	☐
Skin problems (acne, warts, skin cancer, etc.): _____	☐	☐
Neurological problems (multiple sclerosis, migraines, seizures, etc.): _____	☐	☐
Psychiatric / social problems (anxiety, depression, bipolar, insomnia, etc.): _____	☐	☐
Endocrine problems (diabetes, thyroid disorder, pituitary tumor, etc.): _____	☐	☐
Blood/lymphatic problems (high cholesterol, anemia, etc.): _____	☐	☐
Allergic/immune problems (hay fever, lupus, Sjogrens, etc.): _____	☐	☐

PLEASE TELL US IF YOU HAVE EVER… (Please answer and describe): **Yes** **No**

Sustained a head injury or trauma? _____ ☐ ☐

Been diagnosed with Autism or Spectrum Disorder? _____ ☐ ☐

Been diagnosed with Attention Deficit Disorder (ADD) / Attention Deficit Hyperactivity Disorder (ADHD): ___ ☐ ☐

Had any surgeries? _____

Been diagnosed with cancer? What type? _____

ADDITIONAL MEDICAL INFORMATION

Primary Care Physician's Name: _____ Clinic: _____ Last visit: _____

List all prescription medications and any vitamins/supplements/over-the-counter medications you are taking.

(***please include dosage and frequency***): _____

_____

_____

List any medications you are allergic to: _____

Are you pregnant or nursing? ☐ Y ☐ N If yes, when is due/birth date? _____

What is your current height? _____feet _____ inches What is your current weight? _____ pounds

Race: _____ Hispanic or Latino? ☐ Yes ☐ No Preferred Language: _____

How often do you use tobacco products? ☐ Never ☐ Daily (>10/day) ☐ Daily (<10/day) ☐ Sometimes, not daily ☐ Former smoker

How often do you drink alcohol? _____

FAMILY MEDICAL HISTORY: Do your ***family members*** *(grandparents, parents, siblings)* have any of the following?

	Yes	No	If so, who? M=mother, F=father, S=sibling, GP=grandparent
Blindness	☐	☐	_____
Glaucoma	☐	☐	_____
Cataracts	☐	☐	_____
Macular Degeneration	☐	☐	_____
Eye turn (Strabismus)	☐	☐	_____
Lazy eye (Amblyopia)	☐	☐	_____
Retinal Detachment	☐	☐	_____
Rheumatoid Arthritis	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
High blood pressure	☐	☐	_____
Stroke	☐	☐	_____
Heart disease	☐	☐	_____

DEVELOPMENTAL HISTORY – (for patients under 18 years old)

Length of pregnancy: _____ Type of delivery: □ Natural □ C-section □ Forceps/vacuum □ Anesthesia

Child's birth weight: _____ Child is: □ Biological □ Adopted □ Foster □ Other _____

During pregnancy of this child, did any of the following occur?

□ Toxemia □ Trauma □ Injury by fall □ Severe illness □ Prescribed medication

□ Tobacco use □ Alcohol use □ Elicit drug use Please explain: _____

How is your child performing to others his/her age: □ Above average □ Average □ Below average

How well is your child's spoken vocabulary? □ Above average □ Average □ Below average

Has your child undergone any of the following testing / treatment / therapy?

Educational □ Yes □ No Neurological □ Yes □ No Psychological □ Yes □ No

Occupational □ Yes □ No Speech / auditory □ Yes □ No Physical □ Yes □ No

Describe: _____

_____