EyeCare™ Specialties
Center for Vision Development

2917 Pine Lake Road Suite B | Lincoln, NE 68512
(402) 323-2062 | eyecarespecialties.com

Extended Adult Vision Questionnaire

Please fill this questionnaire out carefully and completely.

Appointment Date: ______________________________

Optometrist: ☐ Mikaela Betka, OD, FCOVD

General Information

Patient Full Name: ______________________________

☐ Male ☐ Female Birth Date: ______________ Age: ______________

Home Address: ______________________ City: ______________ Zip: __________

Home Phone: ______________ Cell: ______________ Work: ______________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

What is your occupation? ______________________________

Employer: ______________________________

Were you referred to our office: ☐ Yes ☐ No

If yes, whom may we thank for this referral? Name: ______________________________

Emergency Contact Name: ______________________________

Home Phone: ______________ Cell: ______________ Work: ______________

Family Information

Please list the names of your family.

Spouse: ______________________________

Dependent: ______________________________

Dependent: ______________________________

Dependent: ______________________________

Dependent: ______________________________

Responsible Party Information

Name of responsible party: ____________________

Relationship to patient: ☐ Self ☐ Spouse

Spouse's Employer: ____________________ Work Phone: ____________________

Medical History

Primary Physician: ____________________ Date of last evaluation: ____________________

What prompted the last visit to the doctor? ____________________

____

Your current state of health (explain) ____________________

____

Medications currently using, including vitamins and supplements: ____________________

____

Are you allergic to any foods or medications? ☐ Yes ☐ No

If yes, please list: ____________________

Is there any history of the following?

Diabetes	☐ Patient	☐ Family	Relationship ____________________
High Blood Pressure	☐ Patient	☐ Family	Relationship ____________________
Multiple Sclerosis	☐ Patient	☐ Family	Relationship ____________________
Epilepsy	☐ Patient	☐ Family	Relationship ____________________
Learning Disability	☐ Patient	☐ Family	Relationship ____________________
Crossed or Wall Eye	☐ Patient	☐ Family	Relationship ____________________
Amblyopia/Lazy Eye	☐ Patient	☐ Family	Relationship ____________________
Glaucoma	☐ Patient	☐ Family	Relationship ____________________
Concussion	☐ Patient		
Other (Please explain below)	☐ Patient	☐ Family	Relationship ____________________

____

____

Visual History

Have you had a previous examinations? ☐ Yes ☐ No

If yes, Doctor's name?________________________Date of last visit:____________

Reason for examination:____

Were glasses, contact lenses, or other optical devices prescribed or recommended? ☐ Yes ☐ No

If so, what?________________________Do you use them? ☐ Yes ☐ No

Why do you feel you need a visual evaluation?________________________

____

How long has the problem/difficulty existed?________________________

____

Symptoms

Do you experience any of the following:

Blurred vision at a distance	☐ Yes ☐ No	If yes, when?__________
Blurred vision at near	☐ Yes ☐ No	If yes, when?__________
Red or itchy eyes	☐ Yes ☐ No	If yes, when?__________
Burning or watery eyes	☐ Yes ☐ No	If yes, when?__________
Eyes hurt/ache with near work	☐ Yes ☐ No	If yes, when?__________
Eyes feel tired	☐ Yes ☐ No	If yes, when?__________
Headaches	☐ Yes ☐ No	If yes, when?__________
Nausea associated with visual tasks	☐ Yes ☐ No	If yes, when?__________
Double vision at a distance	☐ Yes ☐ No	If yes, when?__________
Double vision at near	☐ Yes ☐ No	If yes, when?__________
Tilt head during deskwork	☐ Yes ☐ No	If yes, when?__________
Squinting	☐ Yes ☐ No	If yes, when?__________
Covering or closing an eye	☐ Yes ☐ No	If yes, when?__________
Postural changes when doing desk work	☐ Yes ☐ No	If yes, when?__________
Need for very bright light when reading	☐ Yes ☐ No	If yes, when?__________
Need for very dim light when reading	☐ Yes ☐ No	If yes, when?__________

Visual History (continued)

Symptoms

Do you experience any of the following:

Symptom	Response	
Loss of interest/short attention span for close work	☐ Yes ☐ No	If yes, when?______________
Difficulty sustaining reading/writing	☐ Yes ☐ No	If yes, when?______________
General/visual fatigue at the end of the day	☐ Yes ☐ No	If yes, when?______________
Losing place often when reading	☐ Yes ☐ No	If yes, when?______________
Skip lines when reading	☐ Yes ☐ No	If yes, when?______________
Repetition of letter or words when reading	☐ Yes ☐ No	If yes, when?______________
Omission of words when reading/copying	☐ Yes ☐ No	If yes, when?______________
Use of finger to keep place	☐ Yes ☐ No	If yes, when?______________
Head moves when reading	☐ Yes ☐ No	If yes, when?______________
Falling asleep when reading	☐ Yes ☐ No	If yes, when?______________
Silent vocalization/moving lips while reading	☐ Yes ☐ No	If yes, when?______________
Motion/car sickness	☐ Yes ☐ No	If yes, when?______________
Difficulty with reading comprehension	☐ Yes ☐ No	If yes, when?______________
Comprehension decreases over time	☐ Yes ☐ No	If yes, when?______________
Letters or words appear to move or float around when reading	☐ Yes ☐ No	If yes, when?______________
Difficulty aligning columns of numbers	☐ Yes ☐ No	If yes, when?______________
Can respond better orally than in writing	☐ Yes ☐ No	If yes, when?______________
Inconsistent performance in work or sports	☐ Yes ☐ No	If yes, when?______________
Poor general coordination/clumsiness	☐ Yes ☐ No	If yes, when?______________
Poor fine motor coordination/handwriting	☐ Yes ☐ No	If yes, when?______________
Difficulties with short-term memory	☐ Yes ☐ No	If yes, when?______________
Difficulties with long-term memory	☐ Yes ☐ No	If yes, when?______________

Visual Demands

Computers/Electronic Device Use

Do you use a computer or other electronic devices in your work, school, or leisure time activities? ☐ Yes ☐ No

What tasks do you perform?____

____

How many hours do you spend looking at a screen or electronic device each day?____________

How do your eyes feel after working at the computer or electronic device?____________

____

Do you wear any visual correction for computer work? ☐ Glasses ☐ Contact lenses ☐ Other

If other, please explain:____

Employment or School

Current position (if employed):____

Major courses of study (if in school):____

How many hours daily do you spend reading or studying?________________________

How many hours daily 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

If no, please explain:____

Describe briefly your daily activities at work or in school:________________________

____

Hobbies and Sports

Describe the types of activities that comprise the majority of your leisure time:____________

____

Do you watch TV? ☐ Yes ☐ No If yes, how many hours per day?________________________

Are you involved in athletics? ☐ Yes ☐ No

If yes, do you feel you are achieving up to your potential in sports/athletics? ☐ Yes ☐ No

Release of Information

It is often beneficial to us to discuss examination results and to exchange information with other professionals involved in your care. Please sign below to authorize this exchange of information.

I agree to permit information from, or copies of, my examination records to be exchanged with other healthcare providers listed on the back of this release form or upon the recommendation of EyeCare Specialties, P.C. This authorization shall be considered valid throughout the duration of treatment.

____

Patient Printed Name Date

____

Signature of Patient or Authorized Representative

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation of your specific visual needs.

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us at 402-323-2062. You may leave a message for us after the clinic hours and on weekends. We will return your call as soon as possible or the next business day. We request a minimum of 24 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.

Sincerely,

Mikaela Betka, OD, FCOVD
Developmental Optometrist

EyeCare Specialties, P.C. is authorized to exchange and/or share information regarding the treatment of my visual condition to the following health care professionals:

Name:______________________________

School or Business:______________________________

Address:______________________________

City:____________________ State:__________ Zip:__________

Name:______________________________

School or Business:______________________________

Address:______________________________

City:____________________ State:__________ Zip:__________

Name:______________________________

School or Business:______________________________

Address:______________________________

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Address:______________________________

City:____________________ State:__________ Zip:__________

Name:______________________________

School or Business:______________________________

Address:______________________________

City:____________________ State:__________ Zip:__________