learn to see
vision clinic

Welcome to our office!

Please fill out the background history form *as completely as possible* and return to the office **before** your appointment**. Thank you!**

Name _____Birth date___/___/_____ Age_____

Address_____

City _____ State_____ Zip _____

Email Address_____

Home Phone_____ Cell Phone_____

Occupation_____ Work Phone_____

Others living at home with you_____

_____

Vision History

Reason for your visual evaluation_____

_____

In what ways does your vision cause you difficulty? _____

_____

_____

Previous visual examinations (list reason for exams and results)_____

_____

Have any other family members had vision concerns? Please describe._____

_____

Developmental History and School History

Please describe any thing significant about your early childhood developmental

history: _____

Describe your performance in the classroom. Any difficulties with reading or learning?

_____

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Symptoms Checklist--Please check all that apply

- ☐ Headaches
- ☐ Blurred vision
- ☐ Double vision
- ☐ Eyes "hurt" or "tired"
- ☐ Frequent eye rubbing
- ☐ Frequent blinking
- ☐ Closing or covering one eye while reading
- ☐ Head close to paper when reading or writing
- ☐ Tilting head when reading or writing
- ☐ Moves head when reading
- ☐ Confuse or reverse letters or numbers
- ☐ Skip, rereads, or omits words
- ☐ Vocalize when reading silently
- ☐ Read slowly
- ☐ Use finger as marker
- ☐ Poor reading comprehension
- ☐ Write or prints poorly
- ☐ Tire easily
- ☐ Avoid near tasks
- ☐ Short attention span
- ☐ Poor motor coordination
- ☐ Difficulty catching or hitting a ball
- ☐ Confuse right and left
- ☐ Eye turns in or out

Health History

Describe your health history and any serious illnesses. _____

_____

Have you ever suffered a head or neck injury? _____ Please describe: _____

_____

List any medications you are currently taking: _____

Allergies _____

Physician name and address _____

_____

General Information

Please give number of hours you spend daily for the following activities:
Reading or Studying_____ Working on a Computer_____ Watching TV_____

Are you achieving to your potential in work or school?_____

_____

Do you feel you have to put in extra effort into your job or schoolwork?

_____

Describe yourself._____

Interests that fill your spare time_____

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