Midtown Vision Development Center
Better Learning Through Better Vision

The information in this confidential personal history form is critical to the evaluation of your vision

Name_____ Date_____
Date of Birth _____
Address_____City/State _____Zip_____
Preferred Phone (_____)_____ □ Home □ Cell □ Work
Email _____
Date of your last eye examination_____ Have you ever had vision therapy? ❑ Yes ❑ No
Have you ever worn glasses? ❑Yes ❑No Do you wear glasses now? ❑ Yes ❑ No
If yes: ❑ for distance only ❑ for near only ❑ wear them full time ❑ for computer monitor ❑ sports
Do you currently wear contact lenses? ❑Yes ❑No What type? _____
If yes: ❑ wear them full time ❑ for distance only ❑ sports ❑ on occasion / for social events

This is your opportunity to tell us about all areas in which your vision is not serving you well.

What is your main reason for coming here today?
_____
_____

Are there any activities or tasks in work or daily life that are difficult or restricted because of your vision? Please explain.
_____
_____

Please check the conditions that apply to you or that run in your family:

HEALTH HISTORY:
Allergies ❑Self ❑ Family
Respiratory disease ❑Self ❑ Family
Cancer ❑Self ❑ Family
Diabetes ❑Self ❑ Family
Elevated cholesterol ❑Self ❑ Family
High blood pressure ❑Self ❑ Family
Thyroid ❑Self ❑ Family
Migraine or headaches ❑Self ❑ Family
Gastrointestinal disease ❑Self ❑ Family
Heart problems ❑Self ❑ Family
Neurologic conditions ❑ Self ❑ Family

OCULAR HISTORY
Retinal detachment ❑ Self ❑ Family
Color "blind" ❑ Self ❑ Family
Lazy eye ❑ Self ❑ Family
Blindness ❑ Self ❑ Family
Cataracts ❑ Self ❑ Family
Glaucoma ❑ Self ❑ Family
Double Vision ❑ Self ❑ Family
Dry eyes ❑ Self ❑ Family
Flashing lights ❑ Self ❑ Family
Floaters/spots ❑ Self ❑ Family
Eye surgery or injury _____

Please indicate any other medical or ocular conditions you have been diagnosed or being treated for
_____

Have you ever had a history of a head trauma or concussion? ❑ Yes ❑ No
If yes: please fill out or request the Head Trauma Questionnaire

Do you have an eye turn? ❑ Yes ❑ No
If yes: Please fill out or request the Adult Strabismus Form

Are you under a physician's care? ❑No ❑ Yes Dr.'s name? _____Date of last physical_____
Are you regularly taking medications? ❑No ❑ Yes
If yes, please list: 1_____ 2_____ 3_____ 4_____

OCCUPATION: What kind of work do you do?_____

Do you use a computer on your job? . . . . ❑ **Yes** ❑ **No #** hours daily _____
Do you use a computer at home? . . . . . ❑ **Yes** ❑ **No #** hours daily _____

What lenses do you wear? . . . . . ❑ **None** ❑ **glasses** ❑ **bifocals** ❑ **contacts**

When computing, do your eyes bother you? . . . .❑ **Yes** ❑ **No**

When computing do your eyes feel… ? ❑ **red** ❑ **dry** ❑ **ache** ❑ **sore** ❑ **light sensitive** ❑ **blurry**

Do you experience any of the following discomforts at work or at home?

	Yes	No	If yes, when?
Headaches	□	□	
Blurred vision	□	□	
Double vision	□	□	
Tired eyes	□	□	
Eyestrain	□	□	
Motion sickness / car sickness	□	□	
Light sensitivity	□	□	
Closing or covering an eye to see better	□	□	
Need to hold paper close when reading or writing	□	□	
Head tilt	□	□	
Skipping or omitting words when reading	□	□	
Loss of place when reading	□	□	
Need to use finger to keep place	□	□	
Words moving or "swimming" during reading	□	□	
Poor reading comprehension	□	□	
Comprehension decreases over time	□	□	
Write or print poorly	□	□	
Fatigue easily	□	□	
Difficulty with short term memory	□	□	
Difficulty with long term memory	□	□	
Short attention span / loss of interest	□	□	
Difficulty attending to details	□	□	
Poor / awkward general motor coordination	□	□	
Poor fine motor coordination	□	□	
Difficulty judging distances	□	□	
Difficulty driving	□	□	
Dislike / avoid sports	□	□	
Discomfort or dizziness in crowded environments	□	□	

RECREATION AND LEISURE:

In what recreational activities do you participate?_____

Do you wear any special or protective eyewear for your sport? ❑ Yes ❑ No ❑ Not Applicable

Do you feel your vision limits or prevents you from participating in any activities? ❑ Yes ❑ No

If yes, please explain _____

REFERRAL INFORMATION

How were you referred to our office?

❑ Another Doctor/ Therapist ❑ School ❑ Relative ❑ Friend ❑ Insurance ❑ Online Search ❑ Website

If you were referred by another doctor or therapist please fill out with any information you have:

Practitioner name: _____ Specialty_____
Office or School name_____
Phone _____ Fax _____ Email _____
Address _____ City/ State _____ Zip_____
Are you currently undergoing treatment by this physician or therapist? ❑ Yes ❑ No
If yes, for what conditions?_____ How many times per week/month?_____

RELEASE OF INFORMATION:

It is often beneficial for 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 authorize the release of medical information to other health care providers or insurance carriers upon their written request, or upon the recommendation of MIDTOWN VISION DEVELOPMENT CENTER when it is necessary for the treatment of my visual condition or for the processing of insurance claims. This authorization shall be considered valid for the duration of my treatment.

Signature of patient or authorized representative_____Date_____