

NORMAN A. ROSE, O.D. INC.

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www.drnormanrose.com

WELCOME TO OUR OFFICE

Our office is dedicated to servicing our patients with the highest quality of vision care. We use continuing educating to remain at the forefront of our profession and offer the latest eye care technology, professional services and products, we believe that our patients are our friends and that our relationship can last a lifetime.

VISION REHABILITATION QUESTIONNAIRE

Please fill out this form carefully and return it one week before your appointment.

Today's Date: _____ Home Phone: () _____

Work Phone: () _____ Cell Phone: () _____

Mr. Mrs. Miss Ms Child Email Address _____

Patient's Name: _____ Nick Name: _____

Address: _____ City _____ State _____ Zip _____

Birthday: _____ Parent(s) / Guardian (If a child) _____

Siblings (if a child) _____

Patient's Occupation: _____

Employer: _____

Primary Medical Insurance: _____ ID# _____

Vision Insurance: _____ ID# _____

Social Security # _____ Driver's License # _____

Primary Care Doctor: _____ Office Phone: _____

Insured's Name (if different from patient) _____ ID# _____

Insured's Birthday: _____ Insured's Employer _____

Who can we thank for referring you to our office? _____

Friend Doctor Relative School Yellow Pages Other _____

A. MEDICAL HISTORY

Date of injury / accident: _____

Type of injury / accident: _____

- Motor Vehicle Stroke Fall Blow to head Industrial Accident
- Medication-related Drug abuse Poison or toxic substance Carbon dioxide
- Drowning Cord around neck Aneurysm Hemorrhage

Other: _____

WHAT PART OF YOUR HEAD WAS AFFECTED? (check all that apply):

- Forehead Right Side Left Back of head Top of head Face

Was the injury OPEN HEAD (bleeding) or CLOSED HEAD (non-bleeding)? _____

Did you lose consciousness? Yes NO If yes, for how long? _____

Were you in a coma? Yes No If Yes , how long? _____

SYMPTOMS IMMEDIATELY FOLLOWING ACCIDENT / INJURY: (check that apply)

- Double vision Headache Blurred vision Pain in or around eyes Dizziness Vomiting
- Flashes of light Disorientation Loss of balance Neck pain/ whiplash Loss of memory
- Restricted field of view Restricted motion

Other: _____

INITIAL TREATMENT

When did you first see a doctor regarding your accident/injury? _____

Name of Doctor: _____ Specialty: _____

Where were you seen? _____ Were you hospitalized? Yes No How long _____

What were you and your family told? _____

What did the initial treatments consist of? _____

What prognosis/recommendations were you given? _____

Were you given medications? Yes No Medication: _____

For what condition(s)? _____

List any medications, including vitamins and supplements used at the current time: _____

SUBSEQUENT/OTHER PROFESSIONAL CARE

WHAT TYPES OF PROFESSIONAL CARE HAVE YOU RECEIVED OR ARE YOU CURRENTLY RECEIVING?
(check all that apply and described):

Physicians Name: _____ Date: _____

Results and recommendations: _____

Physiatrist Name: _____ Date: _____

Results and recommendations: _____

Neurologist Name: _____ Date: _____

Results and recommendations: _____
Neuropsychologist Name: _____ Date: _____
Results and recommendations: _____
Physical Therapist Name: _____ Date: _____
Results and recommendations: _____
Speech / Language Therapist Name: _____ Date: _____
Results and recommendations: _____
Psychologist / Psychiatrist Name: _____ Date: _____
Results and recommendations: _____
Osteopathic Physicians Name: _____ Date: _____
Results and recommendations: _____
Other / Name: _____
Results and recommendations: _____

Do you have a history of allergies? Yes NO

If yes, please explain: _____

Has a neurological evaluation been performed? Yes NO

If yes, by whom? _____ Date: _____

Results: _____

Has a psychological evaluation been performed? Yes No

If yes, by whom? _____ Date: _____

Results: _____

Has a speech and language evaluation been performed? Yes No

If yes, by whom? _____ Date: _____

VISUAL HISTORY

Have you had a previous vision evaluation? Yes No

If yes, doctor's name: _____

Date of last evaluation: _____

Reason for examination: _____

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

If yes, what? _____

Are they used? Yes NO If yes, when? _____

Were any additional tests, treatments, or therapies recommended concerning your vision?

Yes No If yes, what? _____

Did you undergo these treatments? Yes NO Explain: _____

Results and recommendations: _____

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING:

	<u>Yes</u>	<u>No</u>	<u>Also present before Injury ?</u>
Eye aches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eyes pull or tug	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty moving or turning eyes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pain with movement of eyes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eye redness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Burning eyes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Watery eyes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Itchy eyes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Brightness is bothersome	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Motion sickness / car sickness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blurred vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty changing focus far to near	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Double vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
One eye turns in, out, up or down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Movement of objects in the environment is bothersome	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fluorescent light is bothersome	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Patterned wallpaper or carpets are bothersome	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Head moves when reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lose place often when reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Words jump or move around when reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Short attention span for reading or writing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Skip words frequently when reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Discomfort when reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Loss of interesting /concentration when doing close work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Orient writing/drawing poorly on page	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Squinting, covering or closing one eye	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Head tilts during desk work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Avoid reading or writing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty with dressing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty with bathing/personal hygiene	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty following a series of directions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty using both sides of the body together	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dislike heights	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Awkward, poor balance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dizziness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Confusion / disorientation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	<u>Yes</u>	<u>No</u>	<u>Also present before Injury ?</u>
Get lost often	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bothered by noise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bothered by touch	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty remembering things heard	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty remembering things seen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty remembering name of objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty remembering people's names	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty recalling information known in the past	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty remembering formerly familiar people / object	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty performing tasks formerly easy / routine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty with time management	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty with numbers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty counting money	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Why do you feel the need for a vision evaluation today? _____

LIFESTYLE:

Do you feel your vision interferes with activities of daily living? Yes NO

If yes, please explain (please include effects involving home, work, hobbies social and personal relationships):

What activities comprise the majority of your daily life since your accident/injury? _____

What activities other changes / limitations in your daily life do you attribute to your accident / injury? _____

What do you hope a Visual rehabilitation Program can do for you? _____

EMPLOYMENT/EDUCATION INFORMATION (IF APPLICABLE)

What is current employment position? _____

If a student, what is the major course of study? _____

How many hours daily are spent at a desk? _____

How many hours daily are spent working at near distance? _____

How many hours daily are spent reading / studying? _____

How many hours daily are spent with a computer? _____

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?		NO	YES	?
CONSTITUTIONAL					EARS, NOSE, MOUTH THROAT		
Fever, Weight Loss / Gain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		Allergies / Hay Fever	<input type="radio"/>	<input type="radio"/>
INTEGUMENTARY (Skin)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		Sinus Congestion	<input type="radio"/>	<input type="radio"/>
NEUROLOGICAL					Runny Nose	<input type="radio"/>	<input type="radio"/>
Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		Post-Nasal Drip	<input type="radio"/>	<input type="radio"/>
Migraines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		Chronic Bronchitis	<input type="radio"/>	<input type="radio"/>
Seizures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		Dry Throat / Mouth	<input type="radio"/>	<input type="radio"/>
EYES					RESPIRATORY		
Loss of vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		Asthma	<input type="radio"/>	<input type="radio"/>
Blurred Vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		Chronic Bronchitis	<input type="radio"/>	<input type="radio"/>
Distorted Vision / Halos	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		Emphysema	<input type="radio"/>	<input type="radio"/>
Loss of Side Vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		VASCULAR / CARDIOVASCULAR		
Double Vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		Diabetes	<input type="radio"/>	<input type="radio"/>
Dryness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		Heart Pain		
Mucous Discharge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		High Blood Pressure	<input type="radio"/>	<input type="radio"/>
Redness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		Vascular Disease	<input type="radio"/>	<input type="radio"/>
Sandy or Gritty Feeling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		GASTROINTESTINAL		
Itching	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		Diarrhea	<input type="radio"/>	<input type="radio"/>
Burning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		Constipation	<input type="radio"/>	<input type="radio"/>
Foreign Body Sensation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		GENITOURINARY		
Excess Tearing/ Watering	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		Genitals / Kidney / Bladder	<input type="radio"/>	<input type="radio"/>
Glare / Light Sensitivity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		BONES / JOINTS / MUSCLES		
Eye Pain or Soreness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		Rheumatoid Arthritis	<input type="radio"/>	<input type="radio"/>
Chronic Infection of Eye or Lid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		Muscle Pain	<input type="radio"/>	<input type="radio"/>
Sties or Chalazion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		Joint Pain	<input type="radio"/>	<input type="radio"/>
REVIEW OF SYSTEMS	NO	YES	?		NO	YES	?
Flashes / Floaters in Vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		LYMPHATIC / HEMATOLOGIC		
Tired Eyes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		Anemia	<input type="radio"/>	<input type="radio"/>
ENDOCRINE					Bleeding Problem	<input type="radio"/>	<input type="radio"/>
Thyroid / Other Glands	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		ALLERGIC / IMMUNOLOGIC	<input type="radio"/>	<input type="radio"/>

PSYCHIATRIC

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

Family History

Please note any family history (parent, grandparent, siblings, children; living or deceased) for the following condition:

DISEASE / CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Cataract	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Crossed Eye	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Amblyopia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Glaucoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Macular Degeneration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Retinal Detachment / Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Heart Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Kidney Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Lupus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Thyroid Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

SOCIAL HISTORY:

Do you use tobacco products? NO YES If yes, type / amount/ how long: _____

Do you drink alcohol? NO YES If yes, type / amount/ how long: _____

Do you use illegal drugs? NO YES If yes, type / amount/ how long: _____

REPORT POLICIES

Would you like copies of any reports? Yes No

Would you like copies of any reports sent to anyone else? If so, please list name and address. _____

Please sign below to give us permission to release information to the above sources. (Valid for 90 days only)

Signed _____ Date _____

I, _____ understand that I/MY dependents are eligible for _____ Insurance through MY/SPOUSE'S Employment. I am aware that if the above is not true, I or the person financially responsible for me, are responsible for all charges related to services provide to me. I agree that if the above is not true, I or the person financially responsible will pay in full for all such charges.

Signature

