

Drs. Berger, Taylor & Associates
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Name: _____ DOB: _____ Present Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

Occupation: _____ Referred by: _____ Email: _____

What do you expect to find out from the evaluation? _____

How did you perform in school? Average Above Average Below Average

Do you play sports? Yes No Type & Amount: _____

Other Form of exercise: _____

Do you have any hobbies: _____

How many hours per day do you use: Computer _____ Read _____ Watch TV _____ Play video games _____

Are there any activities that you would enjoy doing, but must restrict because of your vision? Yes No

Please explain: _____

Present Situation:

In what ways are you having visual difficulty? _____

How long have you noticed this difficulty? _____

Previous visual examinations:

Reason for evaluation	Doctor's Name	Date	Result
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you or anyone else ever noticed an eye turn in or wander out? Yes No Which eye? _____

At what age was it first noticed? _____ Have you had eye surgery? Yes No

Do you ever experience any of the following?

Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____	Eyes hurt or tired	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____
Blurred vision @ far	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____	Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____
Blurred vision @ near	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____	Light Sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No	When? _____

Have you ever noticed the following?

Holding reading material too close	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty with short term memory	<input type="checkbox"/> Yes <input type="checkbox"/> No
Holding reading material far away	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty with long term memory	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tilting head when reading	<input type="checkbox"/> Yes <input type="checkbox"/> No	Short attention span	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bumping into objects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty attending to details	<input type="checkbox"/> Yes <input type="checkbox"/> No
Closing/covering one eye when reading	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty driving	<input type="checkbox"/> Yes <input type="checkbox"/> No
Excessive eye rubbing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Get lost in book; Unaware peripherally	<input type="checkbox"/> Yes <input type="checkbox"/> No
Experience fatigue quickly when reading	<input type="checkbox"/> Yes <input type="checkbox"/> No	Avoid sports	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lose place when reading	<input type="checkbox"/> Yes <input type="checkbox"/> No	Motion sickness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Using finger to keep your place when reading	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Health /Family History

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

Systemic Disease/Condition

	Yes	No	Relationship
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drug sensitive	<input type="checkbox"/>	<input type="checkbox"/>	_____
Elevated cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin (acne, cancer)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urogenital (kidney, bladder)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological (MS, seizures)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric (depression, etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____
bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

Ocular Disease/Condition

	Yes	No	Relationship
Lazy eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color “blind”	<input type="checkbox"/>	<input type="checkbox"/>	_____
Light sensitive	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyestrain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Floaters/Spots	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flashing lights	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal detachment or retinal disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head trauma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____

Date of last physical: _____

How is your general health? Excellent Good Fair Poor

Are you currently under a physician’s care? Yes No

Drs. name: _____

Are you taking any medications? Yes No

If so, please list: _____

List any major illness: Age Mild Severe

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

We are looking forward to meeting you and helping you meet your visual needs.

I authorize the release of medical and/or other information pertinent to my care to the insurance company in order for me to be reimbursed.

Signature: _____ Date: _____