



Eye Priority, P.C.
Dr. Kelly de Simone, F.C.O.V.D.
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ACQUIRED BRAIN INJURY VISION QUESTIONNAIRE

Thank you for carefully completing the questionnaire. Please bring it to our office at your appointment time.

Patient's Name _____ DOB _____ Age _____

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

Sex: Male Female Marital Status: Single Married Divorced Widowed

Address _____ City _____ State _____ Zip _____

Phone Number Cell _____ Home _____ Work _____

Email _____ Preferred Method of Contact: Cell Home Work Email

Occupation _____ Employer _____

Spouse/Parent Name _____ Occupation _____

Other household family member's names and ages _____

Responsible Party and Insurance Information

Person responsible for this account _____ Relationship to patient _____

Do you have Major Medical Insurance? Yes No

Insurance Carrier _____ Policy # _____

Insured's Name _____ Insured's DOB _____

Insured's SSN _____ Insured's Employer _____

I authorize the release of my medical and/or other information pertaining to my care at Eye Priority.

Print Name _____

Signature _____

Visual History

What is the reason for today's visit? _____

When did these symptoms first begin? _____

Has the problem gotten better or worse? Please explain _____

Have you had a previous vision evaluation? Yes No
 If yes, doctor's name: _____ Date of evaluation _____

Were glasses, contact lenses or other optical devices recommended? Yes No
 If yes, what? _____
 Are they used? Yes No If yes, when? _____
 If no, why not? _____

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:

Please check if this was a problem prior to injury

- Eyes ache _____
- Eyes pull or tug _____
- Difficulty moving or turning eyes _____
- Pain with movement of eyes _____
- Eyes twitch _____
- Eye redness _____
- Burning, itchy or watery eyes _____
- Bothered by brightness/bright lights _____
- Bothered by noises _____
- Bothered by touch _____
- Motion sickness / car sickness _____
- Headaches _____
- Blurred vision _____
- Difficulty changing focus far to near _____
- Double vision _____
- One eye turns in, out, up or down _____
- Movement of objects in the environment is bothersome _____
- Fluorescent light is bothersome _____
- Patterned wallpaper or carpets are bothersome _____
- Head moves when reading _____
- Lose place often when reading _____
- Words jump or move around when reading _____
- Short attention span for reading or writing _____
- Skip words frequently when reading _____
- Discomfort when reading _____
- Loss of interest/concentration when doing close work _____
- Orient writing/drawing poorly on page _____
- Squinting, covering or closing one eye _____

- Head tilts during desk work _____
- Hold books too close _____
- Avoid reading or writing _____
- Difficulty with peripheral vision _____
- Objects jump in and out of field of view _____
- Reduced depth perception _____
- Tunnel vision / loss of visual field _____
- Flashes of light _____
- Difficulty with dressing _____
- Difficulty with bathing / personal hygiene _____
- Difficulty following a series of directions _____
- Difficulty using both sides of the body together _____
- Dislike heights _____
- Awkward, poor balance _____
- Dizziness _____
- Confusion / disorientation _____
- Get lost often _____
- Bothered by noises _____
- Bothered by touch _____
- Difficulty remembering things heard _____
- Difficulty remembering things seen _____
- Difficulty remembering name of objects _____
- Difficulty remembering people's names _____
- Difficulty recalling information known in the past _____
- Difficulty remembering formerly familiar people/objects _____
- Difficulty performing tasks formerly easy/routine _____
- Difficulty with time management _____
- Difficulty with numbers _____
- Difficulty counting money _____

Do you feel your vision hinders your daily activities in any way? Yes No

If yes, how? _____

Have you noticed any eye turn? Yes No (If no, skip to Medical History)

When did you first notice or suspect eye turn? _____

Did the eye begin turning Suddenly Gradually (please circle one)

Does the eye turn In Out Up Down (circle all that apply)

Is the eye turn getting worse or better, or is there no change? _____

Is it always the same eye that turns? Yes No Right Left

Is the eye turn always present? Yes No
If not, under what conditions is it present? (i.e. when tired, when ill, etc.) _____

Is the eye turn noticed more if you are looking:

Up Close Yes No To your right Yes No

In distance Yes No Up Yes No

To your left Yes No Down Yes No

Has there been any treatment using an eye patch? Yes No
If yes, please describe when the patching was started, how patching was done, including the age it started, the eye patched, the duration of treatment, and an estimate of the results. _____

Does the eye turn less when the prescription is worn? Yes No

Does one pupil ever appear to be larger than the other? Yes No

Do you ever notice one or both eyes shaking rapidly? Yes No

Have you ever been told that you have amblyopia (lazy eye)? Yes No

Has there been any surgical treatment? Yes No
If yes, describe the surgery, including the age surgery was performed, the number of operations, the eye operated on, an estimate of the cosmetic and subjective results. _____

Were you satisfied with the results of the surgery? Yes No
Please explain _____

Was the surgeon satisfied with the results of surgery? Yes No
Please explain _____

Medical History

Do you or anyone in your immediate family (parents, grandparents, siblings, children) have any of the following:
(Please circle and **INCLUDE** whom has/had condition)

- | | |
|--|---|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Amblyopia |
| <input type="checkbox"/> Brain Tumor | <input type="checkbox"/> Blindness |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Keratoconus |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Strabismus |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Turned or "lazy" eye |
| <input type="checkbox"/> Surgeries | <input type="checkbox"/> Vision related learning disability |
| <input type="checkbox"/> Thyroid Conditions | |

Date of injury/accident/onset: _____

Type of injury/accident:

- | | |
|---|--|
| <input type="checkbox"/> Blow to head | <input type="checkbox"/> Industrial Accident |
| <input type="checkbox"/> Carbon dioxide | <input type="checkbox"/> Medication-related |
| <input type="checkbox"/> Cord around neck | <input type="checkbox"/> Motor vehicle |
| <input type="checkbox"/> Drowning | <input type="checkbox"/> Poison or toxic substance |
| <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Stroke Aneurysm |
| <input type="checkbox"/> Fall | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hemorrhage | |

What part of your head was affected? (circle all that apply)

Forehead Right side Left side 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, for how long? _____

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

- | | |
|---|---|
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Loss of memory |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Neck pain/whiplash |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pain in or around eyes |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Restricted field of view |
| <input type="checkbox"/> Flashes of light | <input type="checkbox"/> Restricted motion |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Loss of balance | |
| <input type="checkbox"/> Other: _____ | |

Initial Treatment

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

Name of doctor: _____ Specialty: _____

Where were you seen? Hospital Doctor's Office Urgent Care Other: _____

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 List Medications: _____

For what condition(s)? _____

List all medications you are currently taking and for what condition: _____

List any vitamins and supplements you are currently taking: _____

Subsequent or Other Professional Care

What types of professional care have you received or are you currently receiving? (Complete all that apply)

Neurological evaluation? Yes No
If yes, by whom? _____ Date: _____
Results: _____

Psychological evaluation? Yes No
If yes, by whom? _____ Date: _____
Results: _____

Speech and language evaluation? Yes No
If yes, by whom? _____ Date: _____
Results: _____

Neuropsychological evaluation? Yes No
If yes, by whom? _____ Date: _____
Results: _____

Osteopathic evaluation? Yes No
If yes, by whom? _____ Date: _____
Results: _____

Physical therapy evaluation? Yes No
If yes, by whom? _____ Date: _____
Results: _____

Occupational therapy evaluation? Yes No
If yes, by whom? _____ Date: _____
Results: _____

Any other evaluations? Yes No
If yes, by whom? _____ Date: _____
Results: _____

Do you have a history of allergies? Yes No
If yes, please explain: _____

Sports

Are you seriously involved with athletics? Yes No

Do you feel you are achieving up to your potential in sports/athletics? Yes No

Of all the sports you have played, list the ones in which you:

Excel: _____

Avoid or do poorly: _____

Hobbies/Leisure Time

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

Do you watch TV? Yes No What is the size of the TV you watch? _____ Distance from TV? _____

If yes, how many hours per day? _____

How many days per week do you watch TV? _____

Do you play video games? Yes No Which system? _____ Size of TV or Monitor? _____
 If yes, how many hours per day? _____
 How many days per week do you play video or computer games? _____
 Do you play games on the computer or TV? _____ Distance from TV or computer? _____
 Do you use a Smart Phone? Yes No If yes, how many hours per day? _____

Computers

When do you use a computer? (circle all that apply) Work School Leisure activity

What types of computer work you perform? (circle all that apply)

Word processing	Internet
Programming	Games/Leisure activities
Data entry	Other (explain) _____
E-mail	_____

What type of computer do you use? (circle all that apply) Laptop Desktop
 Please indicate your monitor size _____

What is the distance from:
 Your eyes to the screen? _____
 Your eyes to the keyboard? _____
 Your eyes to your source documents? _____

Where is the top of the screen located? (circle one)
 Above eye level
 At eye level
 Below eye level

Where is the computer screen located when you are seated? (circle one)
 Directly in front of you
 To your right
 To your left

Where are your source documents located?
 Directly in front of you when seated Flat (horizontal)
 To your right Vertical
 To your left

Do you experience any of the following lighting problems in your work area?
 Glare from windows or other light sources Yes No
 Reflections on your computer screen Yes No
 Difficulty reading source documents Yes No

Do you wear glasses, contact lenses, or other optical devices for computer work?
 Glasses Yes No
 Contact lenses Yes No
 Other (explain): _____

How many hours do you spend in front of a computer screen each day? _____
 How do your eyes feel after working at the computer? _____

What 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? _____

Is there any other information you feel would be helpful/important as we treat you?

Form completed by _____
Name **Relationship to Patient**



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RECORDS RELEASE/REQUEST

TO: _____
(Doctor/Hospital/School)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

I hereby authorize the release of my copied medical records. I request that they be transferred to:

Eye Priority
15725 South 46th Street, Suite 112
Phoenix, AZ 85048
Phone: (480) 893-2300
Fax: (480) 893-0522

Print Name of Patient

From: _____ To: _____
Date of Records

Signature of Patient/Parent/Guardian **Date**

This authorization shall be considered valid for 12 months from date signed.