EYE Health Centre

#114, 506 St. Albert Trail
St. Albert, AB
T8N 5Z1
780-419-7000

Patient History Questionnaire

Please fill out the questionnaire carefully and return it to the office at the time of your appointment. The time spent answering questions will allow the doctor to better plan the flow of the examination procedures.

Thank you for your time and effort in completing this questionnaire. Leave blank or put N/A besides questions that do not apply.

PRESENT SITUATION AND SYMPTOMS

What are the concerns that prompted this functional vision evaluation?

_____
_____
_____
_____

How long have these concerns been observed? _____

What goals do you hope to accomplish from this functional vision evaluation?

_____

VISUAL HISTORY

Last Eye Exam (year) _____ Doctor: _____ City: _____

Were glasses, contact lenses or other optical devices prescribed or recommended? If so, what? And do you use them? If not using them, why?

_____
_____

Explain any history of eye surgeries, eye/head injury, vision therapy or other treatments in the past (related or not to current concerns:

_____
_____
_____

OVDRA Optometric Vision Development & Rehabilitation Association

Quality of Life Checklist

Check the column which best represents the occurrence of each symptom	Never 0	Seldom 1	Occasionally 2	Frequently 3	Always 4
Blurred close vision	○	○	○	○	○
Double vision	○	○	○	○	○
Headaches with near work	○	○	○	○	○
Words run together reading	○	○	○	○	○
Burning, itchy, watery eyes	○	○	○	○	○
Falls asleep reading	○	○	○	○	○
Sees worse at the end of day	○	○	○	○	○
Skips/repeats lines reading	○	○	○	○	○
Dizzy/nauseated by near work	○	○	○	○	○
Head tilt/one eye closed to read	○	○	○	○	○
Difficulty copying from chalkboard	○	○	○	○	○
Avoids near work/reading	○	○	○	○	○
Omits small words when reading	○	○	○	○	○
Writes uphill/downhill	○	○	○	○	○
Misaligns digits/columns of numbers	○	○	○	○	○
Poor reading comprehension	○	○	○	○	○
Poor/inconsistent in sports	○	○	○	○	○
Holds reading too close	○	○	○	○	○
Trouble keeping attention on reading	○	○	○	○	○
Difficulty completing work on time	○	○	○	○	○
Says "I can't" before trying	○	○	○	○	○
Avoids sports/games	○	○	○	○	○
Poor hand/eye coordination	○	○	○	○	○
Poor handwriting	○	○	○	○	○
Does not judge distance accurately	○	○	○	○	○
Clumsy, knocks things over	○	○	○	○	○
Poor time use/management	○	○	○	○	○
Does not make change well	○	○	○	○	○
Loses things/belongings	○	○	○	○	○
Car or motion sickness	○	○	○	○	○
Forgetfulness/poor memory	○	○	○	○	○
Total for each column:	___x 0 = 0	___x1 =____	___x2 =____	___x3 =____	___x4 =____

Grand Total: 0

<15 = Routine eye exam recommended

16-24 = Comprehensive exam with developmental OD recommended

>25 = Developmental vision problem likely, comprehensive exam with developmental OD strongly recommended

Any other symptom/concerns not mentioned in the previous checklist?

_____

COMPUTER

Do you use computers in your work, school or leisure time activities? _____

If so, indicate the types of computer work you perform:

☐ Word processing ☐ Programming ☐ Data Entry ☐ Internet

☐ Games Others: _____

How many hours do you spend in front of a computer screen in a day? _____

How do your eyes feel after working at the computer? _____

Do you use multiple screens? _____

Is your computer screen about arm's length away from you? _____ If not, what distance is it? ____

HOBBIES/SPORTS

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

_____

Do you watch TV? ☐ yes ☐ no If yes, how many hours per week? _____

Are you involved in athletics? ☐ yes ☐ no

List the sports in which you participate: _____

Are there any activities/sports you would like to participate in but don't? If so, please explain

_____

_____

EMPLOYMENT OR SCHOOL

Current Position: _____ or Major course of study: _____

How many hours per day do you spend sitting at a desk? _____

How many hours per day do you spend reading of studying? _____

How many hours per day do you spend working at near distances? _____

Do you feel you are achieving your potential at work or school? ☐ yes ☐ no

Do you feel you are getting adequate return from the amount of effort you put into a task? ☐yes ☐ no

Have you ever had a concussion ☐yes ☐ no. If yes, give details

_____

_____

Submit