266 Lamp & Lantern Village, Town & Country, MO 63017 ph (636)527-8877, fax (636)527-8897, IL (618)444-8570, www.drdibler.com

ADULT VISION QUESTIONNAIRE - EXTENDED

Please fill out this questionnaire carefully. Please return it to our office prior to your appointment in the envelope provided. Thank you.

Appointment: Day ____________ Date ______________ Time ___________
Patient's Name: ____

GENERAL INFORMATION

Full Name: ______________________________________ Male ☐ Female ☐
Birth Date: _________ Age: ____
Home Address: ____
Home Phone: __________ Work Phone: ___________ Cellular Phone: __________
Marital status: Single ☐ Married ☐ Divorced ☐ Widowed ☐
Were you referred to our office? Yes ☐ No ☐
If yes, whom may we thank for this referral? ____________ Phone: __________
Address ____
What is your occupation? ____________________ Employer: ______________
Business Address: ____
Spouse's Name: ________________________ Occupation: _____________
Spouse's Employer: _____________________ Phone #: _______________
Business Address: ____

RESPONSIBLE PERSON INFORMATION

Name: ____
Home Address: __________________ City:__________ Zip: ___________
Home Phone: ________________Cellular Phone _________email ___________
Father / Caretaker's Occupation: _______Business Phone: ________email ___________
Business Address: __________________ City: __________ Zip: ___________
Mother / Caretaker's Occupation: ________ Business Phone: ________ email ________
Business Address: __________________ City: __________ Zip: ___________
Do you have Major Medical Insurance? Yes ☐ No ☐
If so, who is the carrier? ____________________ Policy #: _______________
Name of Insured: ____________ SS #__________ Group #: _______________
Does the insurance cover eye examinations or glasses? Yes ☐ No ☐

Please list your spouse and dependents:

	NAME	
Spouse	______________________________	Birth Date ____________
Dependent	______________________________	Birth Date ____________
Dependent	______________________________	Birth Date ____________
Dependent	______________________________	Birth Date ____________
Dependent	______________________________	Birth Date ____________

MEDICAL HISTORY

Date of most recent evaluation: ____________________ Physician's Name: ______________________________

For what problem / condition? ____

Results and recommendations: ____

Medications currently using including vitamins and supplements: ____________________________________

For what condition(s)? ____

Are you allergic to any foods or medications? Yes ☐ No ☐

If yes, please list: ____

Current diet: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Current state of health (explain): ____

Is there any history of the following? (please check if there is a history)

	Patient	Family	Who		Patient	Family	Who
Diabetes	☐	☐	______	Strabismus / crossed eye	☐	☐	______
Multiple Sclerosis	☐	☐	______	Amblyopia / lazy eye	☐	☐	______
Blindness	☐	☐	______	Thyroid Condition	☐	☐	______
Glaucoma	☐	☐	______	Cataracts	☐	☐	______
High Blood Pressure	☐	☐	______	Brain Tumor	☐	☐	______

VISUAL HISTORY

Have you had a previous vision examination? Yes ☐ No ☐

If yes, doctor's name: ____

Date of last visit: ________________

Reason for examination: ____

Results and recommendations: ____

____

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

If so, what? ____

Do you use them? Yes ☐ No ☐

How long have you had them? _______________________

If used, when? ____

If not, why not? ____

If you wear contact lenses, how long have you worn them? ______________________________________

What types of lenses do you have (i.e. hard, soft, gas-permeable)? ___________________________

What solutions do you use? ____

Members of the family who have had visual attention and the reason:

Name	Age	Visual Situation
______________________________	____	____
______________________________	____	____
______________________________	____	____

PRESENT SITUATION

Why do you feel the need for a visual evaluation? ______________________________

____

How long has this problem/difficulty existed? ______________________________

Do you experience any of the following:	Yes	No	If yes, when?
Blurred vision at distance	☐	☐	________
Blurred vision at near	☐	☐	________
Red or itchy eyes	☐	☐	________
Burning eyes	☐	☐	________
Frequent Sties	☐	☐	________
Watery eyes	☐	☐	________
Eyes hurt	☐	☐	________
Eyes feel tired	☐	☐	________
Headaches	☐	☐	________
Nausea associate with visual tasks	☐	☐	________
Halos around lights	☐	☐	________
Double vision at distance	☐	☐	________
Double vision at near	☐	☐	________
Tilt head during desk work	☐	☐	________
Squinting, covering or closing one eye	☐	☐	________
Postural changes when doing desk work	☐	☐	________
Need for very bright light when reading	☐	☐	________
Need for very dim light when reading	☐	☐	________
Loss of interest or short attention span for close work	☐	☐	________
Difficulty sustaining reading / writing	☐	☐	________
General or visual fatigue at the end of the day	☐	☐	________
Loss of place often when reading	☐	☐	________
Skip lines when reading	☐	☐	________
Repetition of letter or words when reading	☐	☐	________
Omission of words when reading / copying	☐	☐	________
Use of finger to keep place	☐	☐	________
Head moves when reading	☐	☐	________
Confusion of what is being seen or read	☐	☐	________
Falling asleep when reading	☐	☐	________
Silent vocalization/moving lips while reading	☐	☐	________
Motion / car sickness	☐	☐	________
Difficulty with reading comprehension	☐	☐	________
Comprehension decreases over time	☐	☐	________
Letters or words appear to move or float around when reading	☐	☐	________
Difficulty aligning columns of numbers	☐	☐	________
Can respond better orally than in writing	☐	☐	________
Write or print poorly	☐	☐	________
Poor time management	☐	☐	________
Inconsistent performance in work or sports	☐	☐	________
Poor general coordination / clumsiness	☐	☐	________
Poor fine motor coordination	☐	☐	________
Difficulties with sort-term memory	☐	☐	________
Difficulties with long-term memory	☐	☐	________

Comments on any items above: ______________________________

____

____

____

COMPUTERS

Do you use a computer in your work, school, or leisure time activities? Yes ☐ No ☐

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

- ☐ Word processing
- ☐ Programming
- ☐ Data entry
- ☐ Internet
- ☐ Games / Leisure activities
- ☐ 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? ______________________

- ☐ Where is the top of the screen located?
- ☐ Above your straight-ahead eye level
- ☐ At eye level
- ☐ Below eye level

What is the distance from: Your eyes to the screen? ______________

Your eyes to the keyboard? ______________

Your eyes to your source documents? ______________

Where is the computer screen located?

- ☐ Directly in front of you when seated
- ☐ To your right
- ☐ To your left

Where are your source documents located?

- ☐ Directly in front of you when seated
- ☐ To your right
- ☐ To your left
- ☐ Flat (horizontal) or vertical

Do you experience any of the following lighting problems in your work area?

- ☐ Glare from windows or other light sources
- ☐ Reflections on your computer screen
- ☐ Difficulty reading source documents

Do you wear glasses, contact lenses, or other optical devices for computer work?

- ☐ Glasses
- ☐ Contact lenses
- ☐ Other (explain): ______________________________

Please describe any problems you have with your vision, current glasses or contact lenses for computer work:

____

____

____

EMPLOYMENT OR SCHOOL

Current position: ______________________ Major course of study: ______________

How many hours daily do you spend at a desk? ______________________

How many hours daily do you spend reading or studying? ______________________

How many hours daily do you spend working at near distances? ______________________

Do you feel you are achieving to your potential in work or school? Yes ☐ No ☐

Do you feel you are getting adequate return for the amount of effort you put into a task? Yes ☐ No ☐

If no, please explain: ______________________

Does your work or course of study demand comprehension from the written word? Yes ☐ No ☐

Describe briefly your daily activities at work or in school: ______________________

____

HOBBIES/SPORTS

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

____

____

Do you watch TV? Yes ☐ No ☐

If yes, how many hours per day? ______________

How many days per week? ______________

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: ______________________

List the ones in which you do poorly/avoid: ______________________

RELEASE OF INFORMATION AND INSURANCE FILING

IT IS OFTEN BENEFICIAL TO US TO DISCUSS EXAMINATION RESULTS AND TO EXCHANGE INFORMATION WITH OTHER PROFESSIONALS INVOLVED IN HIS/HER CARE. PLEASE SIGN BELOW TO AUTHORIZE THIS EXCHANGE OF INFORMATION AND USE OF PHOTO'S FOR PROFESSIONAL EDUCATIONAL PURPOSES.

I authorize the release of medical information to other health care providers or insurance carriers upon their written request, or upon the recommendation of Lisa B. Dibler, O.D., 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

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation and to better meet your specific visual needs.

If at any time you have any questions or concerns regarding your vision or treatment, please do not hesitate to contact us. You may leave a message for us 24 hours a day / 7 days a week.

We request a minimum of 24 hours notice if you are unable to keep this appointment.

Please be on time for your evaluation so that we may have the maximum opportunity to evaluate your visual status.

Thank you.

Sincerely,

Lisa B. Dibler, O.D.