Owen Leigh Optometry

The Vision Therapy Clinic
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Full name: ____________________ Title: Mr/Mrs/Miss/Other: ____________
Home address: ____________________ Birth date: ____________
____________________ E-mail: ____________
____________________ Tel No: ____________
Post code: ____________________ Mobile No: ____________

Advised by: ____________________

YOUR PRESENT SITUATION

Describe your main concern or visual difficulty:

Do you feel your vision hinders your daily activities in any way? If so, how?

Please provide one tick for occasionally, two ticks for often. Add comments below.

- ____ Reduced visual acuity at distance/near*
- ____ Blur at distance or near* after reading
- ____ Occasional double vision at near or distance*
- ____ Eyes itch, burn, tear, red at distance or near*
- ____ Omission of words when reading or copying material
- ____ Frequent loss of place when reading or copying
- ____ Re-reading for comprehension
- ____ Confusion of what is being seen or read*
- ____ Short attention span when performing visual tasks
- ____ Repetition or sequence errors writing
- ____ Difficulty judging distances in sports and/or driving
- ____ Clumsiness/awkwardness in general movement activities
- ____ General or visual* fatigue at end of day
- ____ Covering or closing one eye (when?)
- ____ Headaches (when?)
- ____ Likes head close to the page
- ____ Letters or words appear to float around
- ____ Use of finger or marker to keep place reading
- ____ Excessive head movement when reading
- ____ Head tilt or turn
- ____ Postural changes when doing desk work
- ____ Difficulty aligning columns of numbers
- ____ Poor pen control

*Delete or highlight. Comments on any above checked items:

VISUAL HISTORY

Previous eye examinations: Practitioner's name: ____________ Date: ____________
Reason for examination: ____________________
Results/Advice: ____________________

Do you wear glasses or contact lenses? ____________ When? ____________
When did you first wear glasses? ____________
How long have you had the present lenses? ____________

Please give details of any infections, injuries or any other eye problems that needed treatment:

Members of the family who have received visual attention, (e.g. glaucoma, cataracts, retinal conditions):

Name	Relation	Age	Visual situation

MEDICAL HISTORY

Most recent medical examination: Date: ______ GP's name: ______

Address: ______

Results: ______

Do you have a history of the following: blood pressure, glaucoma, diabetes, thyroid condition?

Medications you are currently using and for what condition:

Any dietary supplements:

EMPLOYMENT AND STUDY

Current position: ______

Describe briefly your daily activities at work or college: ______

How much time do you spend:

At a desk? ______ Reading or studying? ______ On computer? ______ Eye to screen distance? ______ cm

Do you feel you are getting adequate return for the amount of effort you put into a task?

Any additional courses of study?

DAILY ROUTINE & RECREATION

Do you drive regularly? ______ How many miles per week? ______

How much do you watch TV? Hours per day: ______ Days per week: ______ Distance ______ m

Describe the activities that comprise the majority of your spare time: ______

In what sports are you currently involved? ______

Do you feel you are achieving your potential? ______

Of all the sports you have played, which were you good at: ______

Which were you poor at: ______

Form completed by:

Signed:

Name: ______ Date: ______

RELEASE OF CLINICAL INFORMATION

We cannot disclose information without your prior signed approval. If you would like us to be able to share information with anyone other than yourself (such as a relative, solicitor or case manager), please ask for a copy of our authorisation form.

Please return the completed form at your earliest convenience. The information supplied will allow for more effective use of time and permit me to direct my attention to those aspects of vision that are most relevant to you.

Thank you for completing this questionnaire.