

VISION THERAPY ASSOCIATES OF YORK
Christa Roser, O.D. and Robert Hollenbach, O.D.
2649 Carnegie Road, York, PA 17402

ADULT HISTORY FORM

FULL NAME _____

NAME YOU LIKE TO BE CALLED _____

BIRTHDAY _____ AGE _____

ADDRESS _____
(Street, City, State and Zip Code)

PHONE _____ DAYTIME NUMBER _____

OCCUPATION _____

PRESENT SITUATION

1. Why do you think you need a visual examination? _____

2. When did you first notice this difficulty? _____

3. Did this difficulty occur suddenly, or was it related to any specific illness, injury, or other occurrence?

GENERAL HEALTH

1. Are there any general health considerations/conditions at this time? _____

2. Are you taking any medications at this time? _____

If so, please list and describe purpose of each _____

3. Is there any history of allergies or asthma? _____

If so, please describe frequency and treatment _____

4. Is there a history of injuries or accidents? _____

Involving Head? _____ Involving Eyes? _____

5. Is there any special history involving diet or sleep patterns? _____

OVER

VISUAL HISTORY AND CHECKLIST

1. Has there been previous visual care (when and where)? _____

2. Do you have glasses/contact lenses? _____
At what age did you begin wearing glasses? _____
Why and when are they to be worn? _____
When are they actually worn? _____
3. Is there any history of an eye turning, lazy eye, eye disease, eye surgery, eye injury, vision therapy, or patching? _____

4. Have parents, brothers, or sisters had visual care? _____
For what reason? _____

5. Please circle the appropriate response for each symptom:

F (frequently) 0 (occasionally) R (rarely) N (never)

- | | |
|---------|---|
| F O R N | Blurred vision |
| F O R N | Watering, tired, strained, sore eyes (<i>circle ones which apply</i>) |
| F O R N | Double vision |
| F O R N | Headaches late in day or with close work |
| F O R N | Difficulty keeping place while reading |
| F O R N | Uses finger or marker to keep place |
| F O R N | Skipping or re-reading words |
| F O R N | Difficulty copying from board or book |
| F O R N | Confusing similar words |
| F O R N | Reversing words or letters |
| F O R N | Confusing left and right |
| F O R N | Slow or word-by-word reading |
| F O R N | Avoiding reading or close work |
| F O R N | Words running together or moving |
| F O R N | Dizziness or nausea with close work or in car |
| F O R N | Difficulty remembering/comprehending what was read |
| F O R N | Holding head close to reading material |
| F O R N | Turning, tilting, or moving head while reading |
| F O R N | Closing or covering an eye while reading or outside |
| F O R N | Poor handwriting |
| F O R N | Awkward posture or pencil grip when writing |
| F O R N | Tension, nervousness, frustration with close work |
| F O R N | Bright light bothering eyes |

Please include any additional comments or pertinent information: _____

