Developmental Vision and Rehabilitation

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ADULT HISTORY

Name | Date

Referred by ____________________

General Information

Home Phone ____________________ Cell Phone ____________________
Fax Number ____________________ E-Mail ____________________
Home Address ____________________
City ____________________ State ______ Zip ____________________
Social Security Number ____________________ Age ____________________
Birth Date ____________________ Sex *M* *F* Marital Status *S* *M* *D* *W*
If Married, Spouse's Name ____________________
Employer ____________________ Work Phone Number ____________________
Emergency Contact ____________________
Name of Health Care Plan? ____________________
Policy Number ____________________

Visual History

Doctor's name & date ____________________
Results ____________________
Were glasses prescribed? ____________________ Are they worn? ____________________
When? ____________________ Any history of crossing eyes? ____________________
What age first noticed? ____________________ Any family history of crossing eyes? ____________________
Who? ____________________

Other Evaluations

Has a neurological evaluation been performed?______By whom?__________________________

Results:____

Has a psychological evaluation been performed?______By whom?_________________________

Results:____

List any other complaints concerning your vision:____________________________________

____

Visual Demands (Reading, Computer, etc.):

At work ____

At play (sports/hobbies) ____

Health Information

Medications currently taking ____

For what condition? ____

List illnesses, bad falls, head injuries, high fevers etc.

____

Vision Health History

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

Name	Age	Visual Situation

Any history of the following, please check:

	You	Family		You	Family
High Blood Pressure			Headaches/Migraines		
Eye Turn/Strabismus			Sinus Problems		
Diabetes			Lazy Eye/Amblyopia		
Double-Vision			Allergies		
Retinal Disease			Color Deficiency		
Learning Problems			Glaucoma		