



## ADULT HISTORY

Developmental Vision & Rehabilitation

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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
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\_\_\_\_\_

\_\_\_\_\_

Any history of the following, please check:

	You	Family		You	Family
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Eye Turn/Strabismus	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye/Amblyopia	<input type="checkbox"/>	<input type="checkbox"/>
Double-Vision	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Color Deficiency	<input type="checkbox"/>	<input type="checkbox"/>
Learning Problems	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>