OPTOMETRIC VISION CARE ASSOCIATES, INC.

16816 CLARK AVENUE • BELLFLOWER, CALIFORNIA 90706-5793 • (562) 925-6591

PATIENT HISTORY FORM

(revised 10/15)

Today's date _____

Patient Name_____ Date of Birth _____

Address_____

City _____ State _____Zip_____SS#_____

Referring Physician or Professional _____ Phone # _____

Physician Office Address _____

City _____ State _____ Zipcode _____

Neurologist/ Physiatrist/ etc. _____ Phone # _____

Insurance Information (if applicable):

Case Manager _____ Phone # _____ Fax # _____

Address _____ City _____ State ____ Zip _____

Insurance Company _____

Policy/ Group # _____ Claim # _____

Claim Adjuster _____ Phone # _____ Fax # _____

Claim Adjuster Address _____ City _____ Zip _____

A. Present Situation

1. What has led you to request an initial vision examination?

   _____

   _____

2. Who initially suspected the visual difficulties? (teacher, parent, therapist, etc.)

   _____

3. Did this difficulty occur suddenly or did it seem related to illness, accident or any other occurrence?_____

   Date of injury _____Type of Injury _____

   At the time of injury, was there a loss of consciousness? □ Yes □ No

Length of time unconscious _____ Glasgow Coma Scale (if known) _____

Surgery due to injury/ date

_____

Physical limitations (X): □ Wheelchair □ Cane □ Walker □ Crutches

□ Hemiparesis or paralysis on one side (**Right/ Left**)□ Fractures _____

□ Other _____

□ Any specific precautions? _____

Visual Symptoms/ complaints: _____

_____

Physical Complaints: _____

Has your injury prevented you from participating in (x):

□ Personal hygiene care (i.e., inability to tie shoelaces, etc.; please specify)

_____

_____

_____

□ Driving □ Work □ Leisure activities

_____

□ Reading □ Writing □ Speaking □ Walking

□ Home management such as: □ vacuuming □ home repairs □ cleaning □ laundry □ finances

B. General Health

1. Any significant illnesses? Please describe the nature of the illness, at what age the illness occurred and the treatment given if any

   _____

   _____

2. Please check if you have any of the following:

   □ asthma □ eczema □ epilepsy □ seizures □ allergies

   (please describe) _____

3. What current medications are being given and for what? _____

   _____

   _____

4. Has the patient had neurological or psychoeducational testing? When, where and what were the results (Please attach a copy of results if available)?

   _____

   _____

Rehabilitation:

Please check the types of rehabilitation treatment you participate (d) in:

Treatment	Current participation/ Past participation (X) (if past, please include dates of participation)	What day(s) and time (i.e., Tu/ Th 9:00 am)	What treatment was given(please be as specific as possible)
Speech Therapy			
Physical Therapy			
Occupational Therapy			

C. Developmental History (for children only)(Complete Section D instead if not applicable)

1. Full term pregnancy? _____ APGAR score (if known) _____
2. Any complication before, during or immediately after delivery? _____

   _____
3. Approximately at what age did your child crawl?_____ Were there any abnormal patterns with crawling? _____
4. Approximately at what age did your child walk? _____
5. Approximately at what age did your child make speech sounds? _____
6. Name of School_____
7. School Address _____ City _____
8. School Zip Code _____ Phone _____
9. Teacher's Name (s) _____

D. General Behavior

1. What are the usual hours of sleep? _____
2. Have you noted frequent fatigue? _____
3. How do you react to fatigue? (check below)

   a. □ sluggishness □ irritability □ excitability □ other _____
4. Do you have pain? □ yes □ no Where and how often? _____

   _____

5. Do you have visual or behavioral difficulty:
   At home? □ Yes □ No If yes, please describe _____

   At School/ work? □ Yes □ No If yes, please describe _____
6. Do you have a good appetite? □ Yes □ No

6. Have there been elimination problems? □ Yes □ No

7. Do you exhibit the following tensional behaviors: □ nail biting □ eye blinking
   □ eye rubbing (beyond the normal with sleepiness) □ tantrums □ grinding teeth □ other

   Comments: _____

8. Do any of the tensional behaviors seem related to school? □ Yes □ No □ not sure

9. Which hand do you prefer for:

	Right	Left
Eating		
Writing		
Sports		

10. Was handedness ever changed? □ Yes □ No
    (For example, used left hand more than right, but used right hand for writing)

F. Visual History

1. Has there been previous vision care? □ Yes □ No If so, please describe in detail (e.g. glasses, patching, exercises, medications, surgery, etc.) Any treatment using drops? (describe condition and treatment) _____

   _____

2. Any other family members with vision problems? □ Yes □ No If so, please list below.
   Relationship **Problem** **Treatment**

   _____

   _____

   _____

   _____

G. Recreation and Leisure

1. Occupation (pervious or current) _____

   Duties performed at work_____
   _____

Hobbies: _____

_____

2. In what recreational activities do you participate? (circle all that apply)
   Swimming, basketball, baseball, soccer, building models, sewing, dance, reading, playing instruments, crafts, rollerblading

   Please list any other sports/activities _____

3. Do you use a computer at home? □ Yes □ No Number of hour/day _____
4. Do you play video games? □ Yes □ No
5. Do you watch much television? □ Yes □ No Number of hours/day _____

Goals:

What do you see as the main problem and what would you like to improve?

_____

_____

_____

_____

_____

Information Authorization

The office of ***Optometric Vision Care Associates, Inc.*** has my permission to send and receive any and all pertinent case data.

Signature _____ Date _____