Adult History Form

Berkeley School of Optometry

Name: _____ Birthday: _____/_____/_____ Age: _____ yr _____ mo

Education: _____ Occupation: _____

Phone: _____ Fax: _____ Email: _____

Mailing Address: _____

Who referred you to this clinic? _____ Relationship to referral source: _____

I. Please state the major reason you would like to be examined in our Binocular Vision clinic:

_____

II. Symptoms

VISION:	YES	NO	PERSISTENT SYMPTOMS:	YES	NO
Period of vision loss	☐	☐	Headaches	☐	☐
Blurred distance vision	☐	☐	Dizziness/lightheadedness	☐	☐
Blurred reading vision	☐	☐	Seizures	☐	☐
Eyes hurt	☐	☐	Clumsiness, dropping things, weak grasp	☐	☐
Eyes tire	☐	☐	Changes in hearing	☐	☐
Lazy eye/amblyopia	☐	☐	Ringing in your ears	☐	☐
Double vision	☐	☐	Changes in taste	☐	☐
Eye turn (crossed or wall-eyed)	☐	☐	Changes in smell	☐	☐
Covers one eye at close work	☐	☐	Sensitivity to noise/smell/light	☐	☐
Seing multiple images	☐	☐	Numbness/tingling	☐	☐
Eyes “wobble”(nystagmus)	☐	☐	Difficulties walking	☐	☐
Blinks excessively	☐	☐	Loss of balance	☐	☐
Difficulties at computer station	☐	☐	Frequent pain anywhere	☐	☐
Difficulties seeing/looking sideways	☐	☐			
Holds books closer than normal	☐	☐			

III. Eye Care and Diagnostic Evaluations:

EYE CARE:	YES	NO	OTHER EXAMINATIONS:	YES	NO
Wears glasses	☐	☐	Recent eye exam	☐	☐
Wears contact lenses	☐	☐	Neurological exam	☐	☐
Eye turn as a child	☐	☐	Neuro-ophthalmological exam	☐	☐
Patch/eye therapy as a child	☐	☐	MRI	☐	☐
Previous eye surgery	☐	☐	CT scan	☐	☐
Other visual problems	☐	☐	Skull X-ray	☐	☐
			EEG	☐	☐

IV. General Health and Medical History (Personal and Family):

YOUR MEDICAL HISTORY:	YES	NO	FAMILY MEDICAL HISTORY:	YES	NO
Head Trauma	☐	☐	Heart Disease and/or Hypertension	☐	☐
Concussion	☐	☐	Diabetes	☐	☐
Loss of consciousness	☐	☐	Cancer	☐	☐
Automobile Accident	☐	☐	Migraine	☐	☐
Physical impairment as a child	☐	☐	Neurological/Psychological Disorders	☐	☐
Seizures or high fevers as a child/adult	☐	☐	Learning Disabilities	☐	☐
Allergies and/or asthma as a child/adult	☐	☐			
Heart Disease, Hypertension, Stroke	☐	☐			
Diabetes	☐	☐			
Cancer	☐	☐			
Medications*, **please list on line below**	☐	☐			

Current Medication*:

V. Previous and Current Rehabilitation Therapy:

REHABILITATION THERAPY:	YES	NO	TYPE OF THERAPY, DURATION AND RESULTS
Physical Therapy	☐	☐	
Occupational Therapy	☐	☐	
Speech and Language	☐	☐	
Neuro-psychology	☐	☐	
Rehabilitation Counseling	☐	☐	
Visual Therapy	☐	☐	

VI. What specific type(s) of activities do you enjoy or wish to resume?

PLEASE RESPOND TO THE FOLLOWING QUESTIONS IF YOU HAVE BEEN DIAGNOSED WITH LEARNING DISABILITIES, HEAD TRAUMA OR STROKE:

VII. Education and Cognition:

SCHOOL PERFORMANCE AS A CHILD	YES	NO	PRESENT COGNITIVE CHALLENGES AS AN ADULT	YES	NO
Did you have difficulties in school?	☐	☐	Changes in Short term memory	☐	☐
Were you satisfied with your performance?	☐	☐	Changes in Long term memory	☐	☐
Did your grades really show your ability?	☐	☐	Difficulties understanding what is said to you	☐	☐
Did you have trouble completing written assignments?	☐	☐	Difficulties expressing your thoughts in writing	☐	☐
Did you lose your place while reading?	☐	☐	Frequently losing your place when reading	☐	☐
Did you misread known words?	☐	☐	Difficulties understanding what you read	☐	☐
Did you have difficulties with reading comprehension?	☐	☐	Difficulties with arithmetic or balancing checkbook	☐	☐
Early diagnosis of learning disability	☐	☐			

VIII. Behaviors:

Please try to rate your behaviors at work or home. Place a number in the blank space to the left of the item that best describes the frequency of your behavior.

1 - ALWAYS 2 - FREQUENTLY 3 - OCCASIONALLY 4 - RARELY 5 - NEVER 6 - UNKNOWN

	1 2 3 4 5 6		1 2 3 4 5 6
Hyperactive	● ● ● ● ● ●	Poor peer group relationships	● ● ● ● ● ●
Easily Distracted	● ● ● ● ● ●	Irritable or short-tempered	● ● ● ● ● ●
Short attention span	● ● ● ● ● ●	Depressed mood	● ● ● ● ● ●
Easily frustrated	● ● ● ● ● ●	Difficulties following a series of verbal instructions or directions	● ● ● ● ● ●
Impulsive	● ● ● ● ● ●	Variable performance (from hour to hour/day to day)	● ● ● ● ● ●
Easily fatigued	● ● ● ● ● ●	Reverses letters, words or numbers in reading/writing	● ● ● ● ● ●
Poor ability to organize work	● ● ● ● ● ●	Confusion about right or left	● ● ● ● ● ●
Changes in sleep pattern	● ● ● ● ● ●	Given up hobbies/interests	● ● ● ● ● ●
Feel awkward or clumsy	● ● ● ● ● ●	Difficulties initiating or completing chores/tasks	● ● ● ● ● ●

Signature _____ Date: _____

Other person filling out this form: _____ Relationship to Patient: _____

Comments:

Thank you