



Neil W. Draisin, O.D., FCOVD  
Jennifer M. Smith, O.D.  
Francis W. Shealy, O.D., FAAO  
1470 Tobias Gadson Blvd., Ste. 115  
Charleston, South Carolina 29407  
T: 843-556-20/20 F: 843-763-EYES  
[www.draisinvision.com](http://www.draisinvision.com)

## Vision Rehabilitation Questionnaire

*Please fill out this questionnaire carefully.  
Please return it to our office prior to your appointment. **THANK YOU.***

Appointment: Day \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_  
Patient's Name: \_\_\_\_\_

### GENERAL INFORMATION

Patient's Full Legal Name: \_\_\_\_\_ Male  Female

Patient's Nickname: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Marital Status: Single  Married  Divorced  Widowed

Were you referred to our office? Yes  No

If yes, whom may we thank for this referral? \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

What is your occupation? \_\_\_\_\_ Employer: \_\_\_\_\_

Business Address: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_

### INSURANCE

Do you have Vision Insurance? Yes  No  If yes, who is the carrier? \_\_\_\_\_

Insurance Address: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Subscriber ID# (incl. letter prefix): \_\_\_\_\_ Group #: \_\_\_\_\_

Do you have Medical Insurance? Yes  No  If yes, who is the carrier? \_\_\_\_\_

Insurance Address: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Subscriber ID# (incl. letter prefix): \_\_\_\_\_ Group #: \_\_\_\_\_

**PLEASE REMEMBER TO BRING YOU INSURANCE CARD(S)  
WITH YOU TO YOUR APPOINTMENT**

**MEDICAL HISTORY**

Date of injury/accident: \_\_\_\_\_

Type of injury/accident: Motor vehicle  Fall  Blow to head  Industrial Accident   
Medication-related  Drug abuse  Poison or toxic substance  Carbon dioxide   
Cord around neck  Stroke  Aneurysm  Hemorrhage   
Other: \_\_\_\_\_

WHAT PART OF YOUR HEAD WAS AFFECTED? (check all that apply):

Forehead  Right side  Left side  Back of head  Top of head  Face

Was the injury OPEN HEAD (bleeding) or CLOSED HEAD (non-bleeding)? \_\_\_\_\_

Did you lose consciousness? Yes  No  If yes, for how long? \_\_\_\_\_

Were you in a coma? Yes  No  If yes, how long? \_\_\_\_\_

SYMPTOMS IMMEDIATELY FOLLOWING ACCIDENT/INJURY: (check all that apply)

Double vision  Headache  Blurred vision  Pain in or around eyes  Dizziness   
Vomiting  Flashes of light  Disorientation  Loss of balance  Neck pain/whiplash   
Loss of memory  Restricted field of view  Restricted motion

Other: \_\_\_\_\_

**INITIAL TREATMENT**

When did you first see a doctor regarding your accident/injury? \_\_\_\_\_

Name of Doctor: \_\_\_\_\_ Specialty: \_\_\_\_\_

Where were you seen? \_\_\_\_\_

Were you hospitalized? Yes  No  How long? \_\_\_\_\_

What were you and your family told? \_\_\_\_\_

What did the initial treatments consist of? \_\_\_\_\_

What prognosis/recommendations were you given? \_\_\_\_\_

Were you given medications? Yes  No  Medication: \_\_\_\_\_

For what condition(s)? \_\_\_\_\_

List any medications, including vitamins and supplements used at the current time:  
\_\_\_\_\_

**SUBSEQUENT/OTHER PROFESSIONAL CARE**

WHAT TYPES OF PROFESSIONAL CARE HAVE YOU RECEIVED OR ARE YOU CURRENTLY RECEIVING? (check all that apply and describe):

Physicians Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Results and recommendations: \_\_\_\_\_

Psychiatrist Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Results and recommendations: \_\_\_\_\_

Neurologist Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Results and recommendations: \_\_\_\_\_

Neuropsychologist Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Results and recommendations: \_\_\_\_\_

Osteopathic Physician's Name: \_\_\_\_\_  
Results and recommendations: \_\_\_\_\_

- Physical Therapist Name: \_\_\_\_\_  
Results and recommendations: \_\_\_\_\_
- Occupational Therapist Name: \_\_\_\_\_  
Results and recommendations: \_\_\_\_\_
- Speech/Language Therapist Name: \_\_\_\_\_  
Results and recommendations: \_\_\_\_\_
- Psychologist/Psychiatrist Name: \_\_\_\_\_  
Results and recommendations: \_\_\_\_\_
- Other / Name: \_\_\_\_\_  
Results and recommendations: \_\_\_\_\_

Do you have a history of allergies? Yes  No

If yes, please explain: \_\_\_\_\_

Has a neurological evaluation been performed? Yes  No

If yes, by whom? \_\_\_\_\_ Date: \_\_\_\_\_

Results: \_\_\_\_\_

Has a psychological evaluation been performed? Yes  No

If yes, by whom? \_\_\_\_\_ Date: \_\_\_\_\_

Results: \_\_\_\_\_

Has a speech and language evaluation been performed? Yes  No

If yes, by whom? \_\_\_\_\_ Date: \_\_\_\_\_

Results: \_\_\_\_\_

### MEDICAL HISTORY

Is there any history of the following? (please check if there is a history)

|                     | <u>Patient</u>           | <u>Family</u>            | <u>Who</u> |                        | <u>Patient</u>           | <u>Family</u>            | <u>Who</u> |
|---------------------|--------------------------|--------------------------|------------|------------------------|--------------------------|--------------------------|------------|
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | _____      | Glaucoma               | <input type="checkbox"/> | <input type="checkbox"/> | _____      |
| Diabetes            | <input type="checkbox"/> | <input type="checkbox"/> | _____      | Cataracts              | <input type="checkbox"/> | <input type="checkbox"/> | _____      |
| Thyroid condition   | <input type="checkbox"/> | <input type="checkbox"/> | _____      | Blindness              | <input type="checkbox"/> | <input type="checkbox"/> | _____      |
| Multiple Sclerosis  | <input type="checkbox"/> | <input type="checkbox"/> | _____      | Strabismus             | <input type="checkbox"/> | <input type="checkbox"/> | _____      |
| Brain Tumor         | <input type="checkbox"/> | <input type="checkbox"/> | _____      | Amblyopia              | <input type="checkbox"/> | <input type="checkbox"/> | _____      |
| Stroke              | <input type="checkbox"/> | <input type="checkbox"/> | _____      | Traumatic brain injury | <input type="checkbox"/> | <input type="checkbox"/> | _____      |

### VISUAL HISTORY

Have you had a previous vision evaluation? Yes  No

If yes, doctor's name: \_\_\_\_\_

Date of last evaluation: \_\_\_\_\_

Reason for examination: \_\_\_\_\_

Were glasses, contact lenses, or other optical devices recommended? Yes  No

If yes, what? \_\_\_\_\_

Are they used? Yes  No  If yes, when? \_\_\_\_\_

If no, why not? \_\_\_\_\_

Were any other additional tests, treatments, or therapies recommended concerning your vision?

Yes  No

If yes, what? \_\_\_\_\_  
 Did you undergo these treatments? Yes  No  Explain: \_\_\_\_\_  
 Results and recommendations: \_\_\_\_\_

**DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING:**

|  | <u>Yes</u>               | <u>No</u>                | <u>Prior to Injury</u>   |
|--|--------------------------|--------------------------|--------------------------|
| Eyes ache  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eyes pull or tug                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty moving or turning eyes                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain with movement of eyes                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eyes twitch  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain in or around eyes                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye redness  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Burning eyes   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Watery eyes  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Itchy eyes   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Brightness is bothersome                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Motion sickness/car sickness                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Headaches  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blurred vision                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty changing focus far to near                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Double vision  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| One eye turns in, out, up or down                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Movement of object in the environment is bothersome  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fluorescent light is bothersome                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Patterned wallpaper or carpets are bothersome        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Head moves when reading                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lose place often when reading                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Words jump or move around when reading               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Short attention span for reading or writing          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Skip words frequently when reading                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Discomfort when reading                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of interest/concentration when doing close work | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Orient writing/drawing poorly on page                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Squinting, covering or closing one eye               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Head tilts during desk work                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hold books too close                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Avoid reading or writing                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty with peripheral vision                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Objects jump in and out of field of view             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty judging distances                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tunnel vision/Loss of visual field                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Flashes of light                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty with dressing                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

|   | <u>Yes</u>               | <u>No</u>                | <u>Prior to Injury</u>   |
|---|--------------------------|--------------------------|--------------------------|
| Difficulty with bathing/personal hygiene                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty following a series of directions             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty using both sides of the body together        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dislike heights   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Awkward, poor balance                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizziness   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Confusion/Disorientation                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Get lost often  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bothered by noises                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bothered by touch                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty remembering things heard                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty remembering things seen                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty remembering name of objects                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty remembering people's names                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty recalling information known in the past      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty remembering formerly familiar people/objects | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty performing tasks formerly easy/routine       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty with time management                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty with numbers                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty counting money                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Vision derived nausea                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Why do you feel the need for a vision evaluation today? \_\_\_\_\_

\_\_\_\_\_

**LIFESTYLE**

Do you feel your vision interferes with activities of daily living? Yes  No

If yes, please explain (please include effects involving home, work, hobbies, social and personal relationships): \_\_\_\_\_

\_\_\_\_\_

What activities comprise the majority of your daily life since your accident/injury? \_\_\_\_\_

\_\_\_\_\_

What activities can you no longer engage in due to your visual or other difficulties? \_\_\_\_\_

\_\_\_\_\_

What other changes/limitations in your daily life do you attribute to your accident/injury? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What do you hope a Visual Rehabilitation Program can do for you? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What goals have you set up that you would like us to help you meet? What are your short term and long term goals? \_\_\_\_\_

\_\_\_\_\_

**EMPLOYMENT/EDUCATION INFORMATION (IF APPLICABLE)**

What is your current employment position? \_\_\_\_\_

If a student, what is the major course of study? \_\_\_\_\_

How many hours daily are spent at a desk? \_\_\_\_\_

How many hours daily are spent working at near/distance? \_\_\_\_\_

How many hours daily are spent reading/studying? \_\_\_\_\_

How many hours daily are spent with a computer? \_\_\_\_\_

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation and to better meet your specific visual needs.

If at any time you have any questions or concerns regarding your vision or treatment, please do not hesitate to contact us. You may leave a message for us 24 hours a day, 7 days a week.

We request a minimum of 48 hours notice if you are unable to keep this appointment.

Please be on time for your evaluation so that we may have the maximum opportunity to evaluate your visual status.