Kelvin Van Voorst, OD
Stacie Van Voorst, OD

info@prosperfamilyeyecare.com

PROSPER FAMILY EYECARE

110 N. Preston Rd, Suite 30
Prosper, TX 75078
972-347-2004
972-347-3847 (Fax)
www.ProsperFamilyEyecare.com

ADULT VISION QUESTIONNAIRE - EXTENDED

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

Appointment Date: _____ Time: _____

Patient's Name: _____

GENERAL INFORMATION

Full Name: _____ Male ☐ Female ☐

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? _____

What is your occupation? _____

Spouse's Name: _____ Occupation: _____

MEDICAL HISTORY

Date of most recent evaluation: _____ Physician's Name: _____

For what problem / condition? _____

Results and recommendations: _____

Medications currently using including vitamins and supplements: _____

_____

_____

Are you allergic to any foods or medications? Yes ☐ No ☐

If yes, please list: _____

Current diet: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Current state of health (explain): _____

_____

_____

_____

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

	Patient	Family	Who		Patient	Family	Who
Diabetes	☐	☐	_____	Strabismus / crossed eye	☐	☐	_____
Multiple Sclerosis	☐	☐	_____	Amblyopia / lazy eye	☐	☐	_____
Blindness	☐	☐	_____	Thyroid Condition	☐	☐	_____
Glaucoma	☐	☐	_____	Cataracts	☐	☐	_____
High Blood Pressure	☐	☐	_____	Brain Tumor	☐	☐	_____

VISUAL HISTORY:

Have you had a previous vision examination? Yes ☐ No ☐

If yes, doctor's name: _____

Date of last visit: _____

Reason for examination: _____

Results and recommendations: _____

_____

Do you wear glasses, contact lenses or other optical devices? _____

Do you use them? Yes ☐ No ☐

If used, when? _____

If not, why? _____

How long have you had them? _____

If you wear contact lenses, how long have your worn them? _____

What type of lenses do you have (hard, soft)? _____

What solutions do you use? _____

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

Name	Age	Visual Situation
_____	____	_____
_____	____	_____
_____	____	_____

PRESENT SITUATION

Why do you feel the need for a visual evaluation? _____

_____

_____

_____

How long has this problem/difficulty existed? _____

_____

_____

Do you experience any of the following:

	Yes	No	If yes, when?
Blurred vision at distance	☐	☐	_____
Blurred vision at near	☐	☐	_____
Red or itchy eyes	☐	☐	_____
Burning eyes	☐	☐	_____
Frequent Sties	☐	☐	_____
Watery eyes	☐	☐	_____
Eyes hurt	☐	☐	_____
Eyes feel tired	☐	☐	_____
Headaches	☐	☐	_____
Nausea associate with visual tasks	☐	☐	_____
Halos around lights	☐	☐	_____
Double vision at distance	☐	☐	_____
Double vision at near	☐	☐	_____
Tilt head during desk work	☐	☐	_____
Squinting, covering or closing one eye	☐	☐	_____
Postural changes when doing desk work	☐	☐	_____
Need for very bright light when reading	☐	☐	_____
Need for very dim light when reading	☐	☐	_____
Loss of interest or short attention span for close work	☐	☐	_____
Difficulty sustaining reading / writing	☐	☐	_____
General or visual fatigue at the end of the day	☐	☐	_____
Loss of place often when reading	☐	☐	_____

Skip lines when reading	☐	☐	_____
Repetition of letter or words when reading	☐	☐	_____
Omission of words when reading / copying	☐	☐	_____
Use of finger to keep place	☐	☐	_____
Head moves when reading	☐	☐	_____
Confusion of what is being seen or read	☐	☐	_____
Falling asleep when reading	☐	☐	_____
Silent vocalization/moving lips while reading	☐	☐	_____
Motion / car sickness	☐	☐	_____
Difficulty with reading comprehension	☐	☐	_____
Comprehension decreases over time	☐	☐	_____
Letters or words appear to move or float around when reading	☐	☐	_____
Difficulty aligning columns of numbers	☐	☐	_____
Can respond better orally than in writing	☐	☐	_____
Write or print poorly	☐	☐	_____
Poor time management	☐	☐	_____
Inconsistent performance in work or sports	☐	☐	_____
Poor general coordination / clumsiness	☐	☐	_____
Poor fine motor coordination	☐	☐	_____
Difficulties with sort-term memory	☐	☐	_____
Difficulties with long-term memory	☐	☐	_____

Comments on any items above: _____

_____

_____

COMPUTERS

Do you use a computer in your work, school, or leisure time activities? Yes ☐ No ☐

If so, indicate the types of computer work you perform:

- ☐ Word processing
- ☐ Programming
- ☐ Data entry
- ☐ Internet
- ☐ Games / Leisure activities
- ☐ Other (explain): _____

How many hours do you spend in front of a computer screen each day? _____

How do your eyes feel after working at the computer? _____

Where is the top of the screen located?

- ☐ Above your straight-ahead eye level
- ☐ At eye level
- ☐ Below eye level

What is the distance from: Your eyes to the screen? _____

Your eyes to the keyboard? _____

Your eyes to your source documents? _____

Where is the computer screen located?

- ☐ Directly in front of you when seated
- ☐ To your right
- ☐ To your left

Where are your source documents located?

- ☐ Directly in front of you when seated
- ☐ To your right

- ☐ To your left
- ☐ Flat (horizontal) or vertical

Do you experience any of the following lighting problems in your work area?

- ☐ Glare from windows or other light sources
- ☐ Reflections on your computer screen
- ☐ Difficulty reading source documents

Do you wear glasses, contact lenses, or other optical devices for computer work?

- ☐ Glasses
- ☐ Contact lenses
- ☐ Other (explain): _____

Please describe any problems you have with your vision, current glasses or contact lenses for computer work: _____

_____

_____

EMPLOYMENT OR SCHOOL

Current position: _____ Major course of study: _____

How many hours daily do you spend at a desk? _____

How many hours daily do you spend reading or studying? _____

How many hours daily do you spend working at near distances? _____

Do you feel you are achieving to your potential in work or school? Yes ☐ No ☐

Do you feel you are getting adequate return for the amount of effort you put into a task? Yes ☐ No ☐

If no, please explain: _____

Does your work or course of study demand comprehension from the written word? Yes ☐ No ☐

Describe briefly your daily activities at work or in school: _____

_____

_____

HOBBIES/SPORTS

Describe the types of activities that comprise the majority of your leisure time: _____

_____

_____

Do you watch TV? Yes ☐ No ☐

If yes, how many hours per day? _____

How many days per week? _____

Are you seriously involved with athletics? Yes ☐ No ☐

Do you feel you are achieving up to your potential in sports/athletics? Yes ☐ No ☐

Of all the sports you have played:

List the ones in which you excel: _____

List the ones in which you do poorly/avoid: _____

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

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us. We look forward to meeting you.

Thank you,

The Doctors and Staff