



HOLLYWOOD VISION CENTER-OPTOMETRY
955 CARRILLO DRIVE SUITE 105
LOS ANGELES, CA 90048
(323) 954-5800

Low Vision
Sports Vision
Vision Therapy
Children's Vision
Rehabilitation Vision

VISION REHABILITATION QUESTIONNAIRE

Please fill out this questionnaire carefully. Please return it to our office prior to your appointment via FAX (323)954-5807 or email: admin@hollywoodvision.com **THANK YOU**

MEDICAL HISTORY

Date of injury/accident: _____

Type of injury/accident:

- | | | | | |
|--|---|---|-----------------------------------|---|
| <input type="checkbox"/> Motor Vehicle | <input type="checkbox"/> Hemorrhage | <input type="checkbox"/> Stroke | <input type="checkbox"/> Fall | <input type="checkbox"/> Medication-Related |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Carbon Dioxide | <input type="checkbox"/> Cord Around Neck | <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Blow to head |
| <input type="checkbox"/> Drowning | <input type="checkbox"/> Industrial Accident/ Poison or Toxic Substance | | | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Other: _____ | | | | |

WHAT PART OF YOU HEAD WAS AFFECTED? (Check all that apply):

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

Was your injury OPEN HEAD (bleeding) or CLOSED HEAD (non-bleeding)? _____

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

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

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Headache | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Pain in or around eyes |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Flashes of light |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Neck pain/whiplash | <input type="checkbox"/> Restricted Field of View | <input type="checkbox"/> Restricted Motion |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> 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? No Yes 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? No Yes 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?

Physicians Name: _____ Date: _____
 Address: _____ City: _____ Zip: _____
 Psychiatrist Name: _____ Date: _____
 Address: _____ City: _____ Zip: _____
 Neurologist Name: _____ Date: _____
 Address: _____ City: _____ Zip: _____
 Neurologist Name: _____ Date: _____
 Address: _____ City: _____ Zip: _____
 Physical Therapist Name: _____ Date: _____
 Address: _____ City: _____ Zip: _____
 Speech / Language Therapist Name: _____ Date: _____
 Address: _____ City: _____ Zip: _____
 Psychologist / Psychiatrist Name: _____ Date: _____
 Address: _____ City: _____ Zip: _____
 Occupational Therapist Name: _____ Date: _____
 Address: _____ City: _____ Zip: _____

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? _____
 Results: _____
 Has a speech and language evaluation been performed? Yes No
 If yes, by whom? _____ Date: _____
 Results: _____

MEDICAL HISTORY

Please check if there any history of the following:

	<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: _____

Address: _____

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 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>
Eye ache	<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 objects 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"/>
Difficulty writing/drawing 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 deskwork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<u>Yes</u>	<u>No</u>	<u>Prior to Injury?</u>
Hold books too close when 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"/>
Reduced depth perception	<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 following a series of directions	<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"/>
Difficulty remembering things seen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty remembering names or words	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with numbers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dislike heights	<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"/>

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

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 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? _____

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 or near activities? _____

How many hours daily are spent on a computer? _____

Release of Information and Insurance Filing:

It is often beneficial for us to discuss examination results and to exchange information with other professionals involved in your care. Please sign below to authorize this exchange of information.

I authorize the release of medical information to other health care providers or insurance carriers upon their written request, or upon the recommendation of the Hollywood Vision Center - Optometry when it is necessary for the treatment of my visual condition or for the processing of insurance claims. This authorization shall be considered valid for the duration of my treatment.

Signature of patient or authorized representative

Date

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.

We request a minimum of 24 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. Your visit can take from one (1) hour to (2) two hours.

Payment for Services:

Our office cannot provide you with information regarding the extent of coverage by your insurance company. All we can do is get an estimate based on information that we gather from you and/or your insurance company's website. We are out-of-network for most major medical carriers. Please be prepared to pay for your services and materials at the time of your visit. If you have any questions, please contact our office.

Sincerely,

Elise Brisco, OD, CCH, FAAO, FCOVD

Please fax forms to (323) 954-5807 or email
admin@hollywoodvision.com
Thank You!