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NYC Pupil Www.NYCPupil.com

ADULT EYE HEALTH HISTORY Name: _____ Date: _____

Address: _____

When was your last exam: _____ Where: _____

Who is your Primary Care Physician: _____

Do you have any MEDICATION ALLERGIES?: _____

_____

Please list all MEDICATIONS you currently use (include over the counter, eye drops and supplements):

_____

List all EYE SURGERIES and INJURIES: _____

Have you been diagnosed with any of the following EYE CONDITIONS (check all that apply):

☐Blindness
☐Cataract
☐Implant Lens Right Eye
☐Implant Lens Left Eye
☐Dry Eye Syndrome
☐Corneal Dystrophy
☐Eye /Eyelid Cancer
☐Glaucoma
☐Hypertensive Retinal Disease
☐Amblyopia / Lazy Eye *
☐Thyroid Eye Disease
☐Macular Degeneration
☐Retinal Detachment
☐Diabetic Retinal Disease
☐Strabismus /Wandering Eye *
*complete strabismus / amblyopia history

Any other eye conditions: _____

Check any of the following symptoms you experience:

☐Change in distance vision
☐Change in near vision
☐Fluctuating vision
☐Double vision
☐Loss of side vision
☐Flashes of light
☐Light Sensitivity
☐New spots or floaters
☐Eye Itching
☐Mucus Discharge or Crusty lids
☐Eye Pain
☐Dryness or burning in eyes
☐Sandy or gritty feeling
☐Excess tearing
☐Eye strain w/reading or computer work**
☐Dizziness or car sickness***
☐Other: _____

VISION HISTORY:

What is your primary vision correction? _____

Have you ever worn contact lenses? _____ Are you interested in contact lenses? _____

Are you interested in Laser Vision Correction? _____

Are your current contact lenses comfortable and working well for you? _____

Do you have additional glasses? (back up, computer, sun, music, etc) _____

What is your primary occupation? _____How many hours a day do you work on a computer?_

List your hobbies or other activities: _____

CURRENT GENERAL HEALTH HISTORY:

Do any of the following conditions apply to you?

☐Allery / Hayfever
☐Asthma
☐Thyroid Disease
☐Cancer
☐Depression
☐ Diabetes (insulin dep)
☐ Diabetes (non-insulin dep)
☐ Stroke
☐Herpes Zoster
☐HIV
☐Hepatitis
☐Migraines
☐High Blood Pressure
☐Low Blood Pressure
☐High Cholesterol
☐Rheumatiod Arthritis
☐Skin Rashes
☐Sinus Problems
☐Seizures
☐Multiple Sclerosis
☐Parkinson's Disease
☐Alzheimer's Disease
☐Head Injury (or whiplash)****
☐Currently pregnant

***complete reading / computer history* ****complete dizziness / motion sensitivity history*

*****complete brain injury / TBI history*

Do you use any of the following: ☐Alcohol ☐Tobacco ☐Recreational Drugs

FAMILY HISTORY: Is there a history of any of the following conditions in your immediate family?

☐Diabetes	☐Rheumatoid Arthritis	☐Glaucoma
☐Retinal Disease	☐Crossed or Wandering Eye	☐Retinal Detachment
☐Amblyopia / Lazy eye	☐Albinism	☐Macular Degeneration

HEAD TRAUMA /// TBI HISTORY

(stroke, head injury, concussion, whiplash, motor vehicle accident, bike accident, brain surgery, etc…)

Date of most recent event: _____

Briefly describe the injury: _____

_____

_____

What part of the head was affected: ☐Forehead ☐Right side ☐Left side ☐Back of head ☐Top of head ☐Face

Was there loss of consciousness? For how long? _____

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

Where you hospitalized? _____

Describe any previous injuries and dates: _____

WHAT TYPES OF PROFESSIONAL CARE HAVE YOU RECEIVED OR ARE RECEIVING DUE TO THIS INJURY?

(list care such as neurological, psychological, occupational therapy, speech, auditory, chiro, osteopathic, acupuncture, neurofeedback)

_____

_____

What is your most significant concern at this time?

_____

PLEASE FILL OUT THE BIVSS SURVEY (separate form)

If you experience any of the symptoms below, please check if the symptom was present before the injury, only after, or both:

Before	After		Before	After	
☐	☐	Dizziness or motion sickness	☐	☐	Dislike heights
☐	☐	Difficulty understanding what is seen	☐	☐	Difficulty using both sides of the body together
☐	☐	Difficulty recognizing words	☐	☐	Memory problems
☐	☐	Difficulty recognizing faces	☐	☐	Difficulty focusing one or both eyes
☐	☐	Difficulty remembering names of objects	☐	☐	Frequent squinting or blinking
☐	☐	Difficulty remembering people's names	☐	☐	Vision appears unstable or shifts from eye to eye
☐	☐	Difficulty with time management	☐	☐	Unusual head tilt or turn
☐	☐	Difficulty finding objects when grouped together	☐	☐	Portions of a page or objects appear to be missing
☐	☐	Patterned wall paper or carpets are bothersome	☐	☐	People or things suddenly appear from one side
☐	☐	Awkward or poor balance	☐	☐	Looking to the side of objects to see them better
☐	☐	Ears ringing / Tinnitis	☐	☐	Tunnel vision
☐	☐	Confusion / Disorientation	☐	☐	Difficulty concentrating on visual tasks
☐	☐	Gets lost often	☐	☐	Difficulty maintaining eye contact
☐	☐	Bothered by noises	☐	☐	One eye turns in, out, up or down
☐	☐	Bothered by touch	☐	☐	Flashes of light

What activities can you no longer engage in due to your injury or accident: _____

_____

_____

Were you referred to our office? Yes ☐ No ☐ Whom may we thank for this referral? _____

Referral address: _____ Phone: _____

If not referred, how did you hear about us? _____

DRY EYE HISTORY

Over the past week, which of the following eye symptoms have you experienced:

☐Burning
☐Dryness
☐Dry mouth
☐Night Driving problems
☐Decreased contact lens wear time
☐Vision fluctuates

☐Redness
☐Grittiness
☐Itching
☐Stinging
☐Eye ache
☐Tearing / Watery eyes

☐Glare
☐Light Sensitivity
☐Mattering on your eyelids
☐Eyelids swollen or red
☐Burning in the morning
☐Artificial tears help but don't last

Do you take omega-3 supplements daily? _____

Do you use Visine or other "get the red out" drops? _____ How often? _____

Have you ever been prescribed RESTASIS eye drops? _____

****

READING AND COMPUTER SYMPTOM CHECKLIST

CISS:

Please answer the following questions about how your eyes feel when **reading or doing close work**.

Points: Never=0 Infrequently=1 Sometimes=2 Fairly often=3 Always=4

1. Do your eyes feel tired? _____
2. Do your eyes feel uncomfortable? _____
3. Do you have headaches? _____
4. Do you feel sleepy? _____
5. Do you lose concentration? _____
6. Do you have trouble remembering what you have read? _____
7. Do you have double vision? _____
8. Do you see words move, jump, swim or appear to float on the page? _____
9. Do you feel like you read slowly? _____
10. Do your eyes ever hurt? _____
11. Do you eyes ever feel sore? _____
12. Do you feel a "pulling" feeling around your eyes? _____
13. Do you notice the words blurring or coming in and out of focus? _____
14. Do you lose your place? _____
15. Do you have to reread the same line of words? _____ Total: __

NOTE: For children a score of 16 or more indicates the need for a binocular vision evaluation. For adults a score of 21 does.

In addition, Check all that apply:

☐Tendency to close or cover an eye
☐Head tilt or movement
☐Poor reading comprehension
paragraph
☐Head too close to the paper while reading or writing
☐Difficulty tracking moving objects, balls, etc…
☐Writing is crooked or poorly spaced
☐Misalignment of digits or columns of numbers
☐Errors copying from chalkboard, computer or book
☐Avoids near work or reading
☐Difficulty completing assignments in the time allotted

☐Reverses or forgets letters, numbers or words
☐Confuses similar looking words
☐Difficulty recognizing the same word on the next
☐Poor spelling
☐Poor visual-motor (eye-hand) coordination
☐Confused left and right
☐Difficulty following a sequence of directions
☐Whispers when reading silently
☐Comprehension decreases over time
☐Does not visualize