ADULT PATIENT QUESTIONNAIRE

Accent Eye Care®

Aleta B. Gong
O. D. • P. C. • F. A. A. O. • F. C. O. V. D.

Board Certified Fellow of the American Academy of Optometry
and the College of Optometrists in Vision Development

NAME_____ DATE OF BIRTH _____
EMPLOYER NAME & ADDRESS _____
HOME PHONE_____ WORK PHONE_____
REFERRED BY_____

ENTERING COMPLAINT / MAJOR CONCERN

1. Please state briefly your main concern and the main problem that you are having:_____
_____
_____

2. What has occurred that has led you to request a visual examination? _____
_____

3. Who first noted your visual difficulties? _____ When? _____

VISUAL HISTORY:

1. Has there been previous visual care? **YES / NO** Please describe in detail (include any information about glasses, patching, vision therapy, medication or surgery): _____
_____

2. Have you noticed any of the following?

Yes	No	
Yes	No	a. Skipping and rereading words and/or letters.
Yes	No	b. Blurred vision during reading or writing.
Yes	No	c. Headaches associated with visual tasks.
Yes	No	d. Complications with print "running together" or "jumping around".
Yes	No	e. Sensation of eyes “not working together".
Yes	No	f. One eye turns in or out, up or down at anytime.
Yes	No	g. Unusual fatigue after visual concentration.
Yes	No	h. Pain around or in the eyes at anytime.
Yes	No	i. Reddened eyes or lids.
Yes	No	j. Excessive tearing of eyes or rubs eyes frequently.
Yes	No	k. Excessive blinking.
Yes	No	l. Frowning, scowling, or squinting with visual tasks.
Yes	No	m. Tilting or turning head while reading.
Yes	No	n. Closing or covering one eye in bright light or during visual tasks.
Yes	No	o. Moving head forward or backward while looking at a distance object.
Yes	No	p. Avoiding close work.
Yes	No	q. Holding a book too close while reading.
Yes	No	r. Reversals when reading (was-saw, on- no) or writing (b for d, p for q).
Yes	No	s. Using a finger as a marker when reading.
Yes	No	t. Transposition of letters or numbers (21 for 12).
Yes	No	u. Poor printing or handwriting.
Yes	No	v. Difficulty in copying from blackboard to paper.

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DEVELOPMENTAL HISTORY

1. Family Placement: Eldest_____ Middle_____ Youngest_____ Only Child_____ Adopted_____
2. What age did you: Crawl_____ Stand_____ Sit Unassisted_____ Walk _____
3. Age of first word (other than mama or dada):_____
4. Other developmental factors: _____

GENERAL HEALTH AND BEHAVIOR

Do you have a history of the following? Please mark any of the following that apply:

Measles	_____	Chickenpox	_____	Frequent Colds	_____
Mumps	_____	Whooping Cough	_____	Meningitis	_____
Asthma	_____	Scarlet Fever	_____	Encephalitis	_____
Allergies	_____	Tonsillitis	_____	Convulsions	_____
Hay Fever	_____	Ear Infections	_____	Broken Bones	_____
Seizures	_____	Pneumonia	_____	Hyperactivity	_____
Epilepsy	_____	Influenza	_____	Depression	_____
Glaucoma	_____	Cataracts	_____	Eye Disease	_____

Head Injury _____ When?_____ Location? _____
Surgery Specifics: _____
_____
_____

1. Did you ever have any severe childhood illnesses, high fevers, injuries, or physical impairment? **YES / NO**
   If yes, please explain: _____
   _____
2. Have you had any ear infections? **YES / NO** If yes, please indicate how often and whether treatment was received:_____
   _____
3. Do you have any food or environmental allergies? **YES / NO**
   If yes, please indicate to what and any treatments that you are receiving:_____
   _____
4. Have you ever had a neurological evaluation? **YES / NO** If yes, please indicate the results:_____
   _____
5. Do you have ANY history of epilepsy or seizures? **YES / NO** _____
6. What medication (such as penicillin or sulpha drugs) has been given and for what?_____
   _____
7. Have you ever had a reaction to a medication? **YES / NO** If yes, please describe _____

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8. Are you currently taking medication(s) **YES / NO** If yes, please list medication and purpose :

	Medication	Purpose
1		
2		
3		
4		
5		

9. Do you smoke? **YES / NO** If yes, How often?_____

10. Do you drink alcohol? **YES / NO** If yes, How often?_____

11. Have you ever had a speech and language evaluation and/or therapy? **YES / NO** If yes, please indicate when and the results:
_____
_____

GENERAL HEALTH AND BEHAVIOR (continued)

12. Do you have frequent periods of extreme fatigue? **YES / NO** If yes, when? _____

13. Does fatigue result in sluggishness, excitability, or irritability? **YES / NO** _____

14. Do you exhibit any tensional behavior such as nail biting, eye blinking or rubbing, tongue chewing or lip biting, etc? **YES / NO** If yes, when? _____

15. Is there a family history of significant reading, writing, or spelling difficulties? **YES / NO** - Who? _____

16. Is there a family history of hyperactivity, attention problems, or speech difficulties? **YES / NO** - Who? _____

17. Do you like to participate in sport activities? **YES / NO** If yes, What? _____

18. What are your special interests? _____
_____

EDUCATIONAL INFORMATION

Levels of education achieved: Elementary _____ High School _____
College _____ Bachelor's _____
Master's _____ Doctorate's _____

1. Did you ever repeat a grade? **YES / NO** If yes, which grade(s)?_____
2. Did you ever attend remedial or special education services?_____
   If Yes, When and for what? _____
3. Did you ever attend speech or language therapy? **YES / NO** If Yes, When and for what problems?_____

_____

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4. Do you like to read? **YES / NO** Do you understand what you read? _____

5. Do you move your lips while reading silently? _____

6. Do you have trouble remembering what you read? **YES / NO**

7. Other pertinent information_____

_____

Thank you for carefully completing this questionnaire.

Would you like a report?_____ To Whom? Please sign your name, giving Accent Eye Care your authorization to send reports to the following:

Name: _____

Address: _____ City: _____ Zip: _____

Name: _____

Address: _____ City: _____ Zip: _____

Name: _____

Address: _____ City: _____ Zip: _____

I give Aleta B. Gong – Tang OD, PC permission to release information to the above people:

Name: _____ Date: _____

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