Accent Eye Care
and Sports Vision Therapy

Adult VT Questionnaire

Name_____ Date of Birth_____
Employer Name & Addr_____
Home Ph_____ Work Ph_____ Cell Ph_____
Referred By_____ Referral Ph_____
Referral Address_____

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	a. Skipping or rereading words/letters or losing place.
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 or soreness 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. Loss of concentration or uncomfortable when reading or doing 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 a whiteboard or screen to paper.
Yes	No	w. Double vision.
Yes	No	x. Reading slowly or trouble remembering what you read.

Aleta B. Gong • O.D. • P.C. • F.A.A.O. • F.C.O.V.D.
16020 North 35th Avenue, Suite #2 • Phoenix, Arizona 85053
Phone (602) 547-3255 • Fax (602) 375-9580 • accenteyes.com

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General Health and Behavior

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

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

1. Have you ever had a Head Injury? **YES / NO** If yes, When and location?_____
   Surgery Specifics: _____
   _____

2. Have you ever had a neurological evaluation? **YES / NO** If yes, please indicate the results:_____
   _____

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

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

	Medication	**Purpose**
1		
2		
3		
4		
5		

5. Have you ever had a reaction to a medication? **YES / NO** If yes, please describe _____
   _____

6. Do you have any food or environmental allergies? **YES / NO** If yes, please indicate to what and any treatments that you are receiving:_____
   _____

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

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

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9. Did you ever have any severe childhood illnesses, developmental delays, high fevers, injuries, or physical impairment? **YES / NO** If yes, please explain: _____
_____

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General Health and Behavior (continued)

10. Do you have frequent periods of extreme fatigue (sluggishness, excitability, irritability) or tensional behavior (nail / tongue / lip biting, eye blinking / rubbing, etc.)? **YES / NO** If yes, please describe:

    _____

11. Is there a family history of: Significant reading, writing, or spelling difficulties? **YES / NO**
    Hyperactivity, attention problems, or speech difficulties? **YES / NO**
    If yes, who? _____

12. What are your special interests (sports, hobbies, etc.)? _____
    _____

Educational Information

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

1. Did you ever attend remedial or special education services? _____
   If Yes, When and for what? _____

2. 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: _____Phone:_____
Address: _____ City: _____ Zip: _____

Name: _____Phone:_____
Address: _____ City: _____ Zip: _____

Name: _____Phone:_____
Address: _____ City: _____ Zip: _____

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

Signature: _____ **Date:** _____

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