VISION CARE CENTER

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Dr. Roger W. Fitch, O.D.
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PATIENT HISTORY FORM

Please complete the following questionnaire as completely as possible. The information will help to plan for the evaluation and to determine your needs. Please return the questionnaire prior to coming in for your scheduled appointment. Please include any additional information, testing and/or reports that may be relevant to the evaluation.

QUESTIONNAIRE **DATE**_____

PATIENT'S INFORMATION

Name_____
Last First Middle

Birth Date_____Age_____Sex_____
Month Day Year Year Month

Address_____Phone:_____
Street

_____
City State Zip

How did you hear about us? _____

Primary Care Physician: _____

Patient's Education:

Levels Completed

Grade School	( )
High School	( )
College or equivalent (years)	( ) _____
Graduate Work	( )

Occupation/Title_____

Comments:

_____
_____
_____

PRESENT SITUATION

Reason for Evaluation:

_____

_____

_____

Who first noticed your visual problem/When? _____

Did problems occur suddenly? _____

Do problems seem to be related to illness, accident, or other trauma?

_____

In the case of accident or trauma, was it work related? YES NO

ORGANIZATION	Never	Sometimes	Often
Trouble keeping on tasks	( )	( )	( )
Do not finish attempted tasks	( )	( )	( )
Do not plan time well	( )	( )	( )

MEDICAL HISTORY	Yes	No
Major illness or trauma	( )	( )

If yes, explain_____

_____

_____

VISUAL HISTORY

Do any family members have eye disease or abnormalities?_____

If yes, explain_____

_____

Do you have glasses now? _____Do wear them full time? _____

If no, when? _____

Do your current symptoms include:	Yes	Sometimes	No	When
Dizziness	( )	( )	( )	
Headaches	( )	( )	( )	_____
Blurred vision (far)	( )	( )	( )	_____
Blurred vision (near)	( )	( )	( )	_____
Double Vision	( )	( )	( )	_____
Eye strain	( )	( )	( )	_____
Bright Lights	( )	( )	( )	_____
Other_____	( )	( )	( )	_____

Have you noticed a tendency to :

Rub your eyes due to burning/itching	( )	( )	( )	_____
Blink Excessively	( )	( )	( )	_____
Have red eyes	( )	( )	( )	_____
Other _____	( )	( )	( )	_____

When you read or write do you:

Reverse letters	( )	( )	( )	_____
Reverse words	( )	( )	( )	_____
Skip or repeat words	( )	( )	( )	_____
Keep place with finger	( )	( )	( )	_____
Move head excessively	( )	( )	( )	_____
Lose place on page	( )	( )	( )	_____
Close or cover one eye	( )	( )	( )	_____
Tilt or turn head	( )	( )	( )	_____
Can you read/write for long periods of time?	( )	( )	( )	_____

PLEASE REQUEST COPIES OF ALL PREVIOUS EVALUATION REPORTS BE SENT TO OUR OFFICE PRIOR TO EVALUATION DATE TO COMPLETE YOUR HISTORY. Thank you.

PLEASE ADD ANY ADDITIONAL COMMENTS OR INFORMATION ON THE REVERSE SIDE.

Signature:_____Date:_____