LAS VEGAS CENTER FOR VISION THERAPY
Vision Development & Rehabilitation

Kareen Yeung Landerville, OD
Fellow, College of Optometrists in Vision Development

Adult Vision Questionnaire

Please fill out this questionnaire carefully, and if possible, return it to our office prior to the appointment. Thank you.

General Information

Patient's Name: ____

Birth Date: ____/____/________ Age: ____ years Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Address: ______________________ City: ____________ State: _______ Zip: __________

Home Phone: (_______) ________ - ___________ Business Phone: (_______) ________ - ___________

Cell Phone: (_______) ________ - ___________ Email: ______________________

Driver's License #: ______________________ Occupation: ______________________

Employer: ______________________ Phone Number: (_______) _______ - __________

Business Address: ____

Spouse's Name: ______________________ Spouse's Occupation: ______________________

Spouse's best number to be reached at: (_______) ________ - ___________

Were you referred to our office? ☐ Yes ☐ No If yes, whom may we thank for this referral? ______________________

Address: ______________________ Phone Number: (_______) _______ - __________

Medical History

Physician's Name: ______________________ Date of Last Visit: ____/____/________

For what reason? ____

Results & Recommendations: ____

____

Medications currently using, including vitamins and supplements: ______________________

____

For what condition(s)? ____

____

Are you allergic to any foods or medications? ☐ Yes ☐ No

If yes, please list: ____

Current Diet: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

List any major illnesses or injuries: ____

____

Current state of health (briefly explain): ____

____

____

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Is there any history of the following (please check all that apply)?

	Patient	Family	Relationship		Patient	Family	Relationship
Diabetes	☐	☐	______________	High Blood Pressure	☐	☐	______________
Eye Turn/Strabismus	☐	☐	______________	“Lazy” Eye/Amblyopia	☐	☐	______________
Blindness	☐	☐	______________	Thyroid Condition	☐	☐	______________
Multiple Sclerosis	☐	☐	______________	Glaucoma	☐	☐	______________
Epilepsy or Seizures	☐	☐	______________	Other	☐	☐	______________

If other, please explain: ______________________________

Visual History

Has your vision been previously evaluated? ☐ Yes ☐ No

If yes, doctor's name: ______________________________ Date of last exam: ____/____/________

Reason for exam: ______________________________

Results/Recommendations: ______________________________

Wear glasses, contact lenses, or other optical devices prescribed? ☐ Yes ☐ No

If yes, what was recommended? ______________________________

Are they used? ☐ Yes ☐ No If yes, when? ______________________________

If not used, why? ______________________________

If you wear contact lenses, how long have you worn them? ______________________________

What type of lenses do you use (*i.e.,* hard, soft, gas-permeable)? ______________________________

What solutions do you use? ______________________________

Please list any immediate family members who have had vision treatment, including the reason for therapy: ______________________________

____

Present Situation

Why do you feel you need a visual evaluation? ______________________________

____

How long has the problem/difficulty been observed? __________ *days/weeks/months/years*

Employment or School

Current Position or Major Course of Study: ______________________________

How many hours per day do you spend at a desk? _________ *hours*

How many hours per day do you spend reading or studying? _________ *hours*

How many hours per day do you spend working at near distances? _________ *hours*

Does your work or course of study demand comprehension of written words? ☐ Yes ☐ No

Briefly describe your daily activities at work or in school: ______________________________

Computer Use

How many hours do you spend in front of a computer screen each day? ______________________________

What is the approximate distance from your eyes to the screen? ______________________________

Do you experience any of the following lighting problems in your work area?

☐ Glare from windows or other light sources ☐ Reflections on your computer screen ☐ Difficulty reading source documents

Do you wear glasses, contact lenses, or other optical devices for computer work?

☐ Glasses ☐ Contact Lenses ☐ Other (please explain): ______________________________

How do your eyes feel after working at a computer? ______________________________

Patient Preference Regarding Communication with Our Office

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

I hereby give my permission for information from, or copies of, my examination records to be forwarded to other health care providers when it is necessary for the treatment of my visual condition. I further authorize representatives of the Las Vegas Center for Vision Therapy to exchange information with other professionals involved in my care. The professionals are listed below. This authorization shall be valid for the duration of treatment or until a written request to the contrary is received.

Name: ____ Relation: ___________________________

Name: ____ Relation: ___________________________

Name: ____ Relation: ___________________________

In addition, if you prefer, we may discuss examination results and exchange information with ***your family member(s) and/or friend(s)*** who are involved in your care. Please provide the information and sign below to authorize this exchange of information.

I hereby give permission to the Las Vegas Center for Vision Therapy to disclose and discuss any information related to my visual and medical condition(s) with the following family member(s) and/or friend(s):

Name: ____ Relation: _________________________

Name: ____ Relation: _________________________

Name: ____ Relation: _________________________

How should we contact you?

□ Home phone □ Work phone □ Cell phone □ Cell phone Text

If we cannot reach you by telephone,

- □ Leave a message with details, including health information
- □ Leave a message with call back number only

If you provide your email address, we may contact you via email for appointment reminders, sending reports, and general correspondence. Emails are sent from our secure system; we will not send health information if you request us to do so.

The information provided on this questionnaire is current and correct to the best of my knowledge, and I hereby give my permission to the doctors and therapists at Las Vegas Center for Vision Therapy to initiate treatment.

_______________________________________ ______________ ______/______/___________

Signature of patient (or parent/legal representative) *Relationship to patient* *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 visual and health evaluation to better meet your specific visual needs. If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us. You may leave a message for us on our secure voicemail or email. We request a minimum of 24 hours notice if you are unable to keep this appointment. Please be on time for your examination so that we will have the maximum opportunity to evaluate your visual status.