



Adult History Form

GENERAL INFORMATION

Full Name _____ Goes by: _____

Street Address: _____

City _____ State: _____ Zip: _____

Date of Birth _____ Age: _____

Occupation: _____

Home Phone: _____

Cell phone: _____

Work phone: _____

Email: _____

Spouse's Name: _____

Spouse's Occupation: _____

Cell phone: _____

Work phone: _____

How did you hear about our center? _____

Who is your medical insurance carrier? _____

PRESENT SITUATION

Why do you wish to be evaluated? _____

List any complaints you have concerning your vision: _____

At what age did the problem begin and under what circumstances: _____

Has the problem become better or worse? _____ Explain: _____

Does anyone else in the family have a similar problem? _____

EDUCATIONAL HISTORY

Highest grade completed in school:_____ Did you enjoy school? Yes No

Specifically describe any school difficulties you experienced:_____

Do you like to read? Yes No

Would you rather be read to than read by yourself? Yes No

What do you enjoy reading?_____

DAILY ACTIVITIES

How many hours daily do you spend at a desk?_____

How many hours are you spending in front of a computer screen?_____

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

Do you feel you are working up to your potential? Yes No

If no, explain_____

Do you feel you are getting adequate return for the amount of effort you put in? Yes No

If no, explain_____

INTERESTS AND HOBBIES

What hobbies and activities do you most enjoy?_____

What hobbies and activities do you least enjoy?_____

Do you watch TV or play video games? Yes No

If yes, how many hours per day?_____ Days per week?_____

Are you involved in any organized sports activities or teams? Yes No

If so, what?_____

Do you enjoy music? Yes No Do you play a musical instrument? Yes No

If so, what?_____

Can you carry a tune? Yes No Can you maintain rhythm when dancing? Yes No

HOME ENVIRONMENT

Who lives in the home? Please give ages, gender, and relationship:

Name	Age	Gender	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Briefly describe your personality: _____

Is there any other information you feel would be helpful/important for your examination?

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us perform a more comprehensive evaluation and to better meet your specific visual needs.

We need a minimum of 15 minutes to review this information; therefore, we require that you arrive no later than 15 minutes prior to your scheduled appointment. If you wear glasses, please bring them to the appointment. If you have a written copy of the prescription, please bring that as well. If you wear contact lenses, please have the doctor that fit the lenses fax us a copy of both the glasses and contact lens prescription.

Please be aware that we will not be dilating your eyes or using drops at the evaluation. If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us.