Date: _____

Adult History Form

GENERAL INFORMATION

Full Name:_____ Goes by: _____

Street Address: _____

City_____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

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

Reason for evaluation: _____
_____
_____

List any observations 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? _____
_____

MEDICAL HISTORY

List any illnesses, seizures, accidents, surgeries, fevers, that you have experienced:

Illness/Injury	Age	Severity	Complications (if any)

_____
_____
_____
_____

Have you ever been diagnosed with ADD, ADHD, LD, Dyslexia, Autism/Autism Spectrum Disorder or any other diagnosis? ☐ Yes ☐ No ☐ Other: _____
_____

List any prescription or over-the-counter medication(s) currently being taken, dosage, name and reason:
_____
_____
_____

Are you aware of any pre- or post-natal issues at the time of your birth? _____
_____

List any developmental delays as a child (crawling, walking, talking, shoe tying, bike riding, etc): _____
_____
_____

VISUAL HISTORY

Have you had a comprehensive eye exam with an Optometrist or Ophthalmologist? ☐ Yes ☐ No
If yes, when was your last eye exam? _____
Clinic name and city: _____

Were glasses recommended at any of your previous vision examination(s)? ☐ Yes ☐ No
Are they used? ☐ Yes ☐ No If yes, when? _____
If not used, why not? _____

Were treatment recommendations made? ☐ Yes ☐ No If yes, explain: _____
_____

Was the treatment program followed? ☐ Yes ☐ No
Was the treatment effective? ☐ Yes ☐ No
Have vision therapy services been pursued previously? ☐ Yes ☐ No
If yes, explain: _____

Members of the family who have had vision treatment and why?

Name	Age	Visual Condition/Treatment

EDUCATIONAL HISTORY

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

Describe any school difficulties you experienced: _____
_____
_____

Do you like to read? ☐ Yes ☐ No Do you prefer audio books over reading? ☐ Yes ☐ No

DAILY ACTIVITIES

How many hours daily do you spend at a desk? _____
How much time do you spend in front of a screen including time at work as well as: TV, iPad, computer, smart phone, video games, etc.)? _____
_____
Viewing distance? _____
How do your eyes feel after working on a screen? _____
_____

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? _____
_____

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 keep rhythm? ☐ 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 evaluation?
_____
_____
_____
_____