



Domiano Eye Care Center  
Old Forge & Kingston, PA

Low Vision  
Sports Vision  
Vision Therapy  
Children's Vision  
Rehabilitation Vision

## VISION REHABILITATION QUESTIONNAIRE

Please fill out this questionnaire carefully. Please bring it with you to your visit. **THANK YOU.**

### GENERAL INFORMATION

Patient Name: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Date: \_\_\_\_\_ Age: \_\_\_\_\_ E-mail \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ Cell ph: \_\_\_\_\_

Marital Status: Single  Married  Divorced  Widowed  Other

How were you referred to our office? \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Do you have Major Medical or Vision Insurance? Yes  No

If yes, who is the carrier? \_\_\_\_\_ Policy#: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Driver's License No.: \_\_\_\_\_

What is your occupation? \_\_\_\_\_ Employer: \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

### MEDICAL HISTORY

Date of injury/accident: \_\_\_\_\_

Type of injury/accident:

- Motor Vehicle       Hemorrhage       Stroke       Fall       Medication-Related
- Drug Abuse       Carbon Dioxide       Cord Around Neck       Aneurysm
- Blow to head       Drowning       Industrial Accident/ Poison or Toxic Substance
- Tumor       Other: \_\_\_\_\_

WHAT PART OF YOU HEAD WAS AFFECTED? (Check all that apply):

- Forehead    Right side    Left head    Back head    Top of head    Face

Was your injury OPEN HEAD (bleeding) or CLOSED HEAD (non-bleeding)? \_\_\_\_\_

Did you lose consciousness? Yes  No  If yes, for how long? \_\_\_\_\_

SYMPTOMS IMMEDIATELY FOLLOWING ACCIDENT/INJURY: (check all that apply)

- Double Vision    Headache    Blurred Vision    Pain in or around eyes
- Loss of balance    Dizziness    Vomiting    Flashes of light
- Loss of memory    Neck pain/whiplash    Restricted Field of View    Restricted Motion
- Disorientation    Other: \_\_\_\_\_

**INITIAL TREATMENT**

When did you first see a doctor regarding your accident/injury? \_\_\_\_\_

Name of Doctor: \_\_\_\_\_ Specialty: \_\_\_\_\_

Where were you seen? \_\_\_\_\_

Were you hospitalized? No    Yes how long? \_\_\_\_\_

What were you and your family told? \_\_\_\_\_

What did the initial treatments consist of? \_\_\_\_\_

What prognosis/recommendations were you given? \_\_\_\_\_

Were you given medications? No    Yes Medication: \_\_\_\_\_

For what condition(s)? \_\_\_\_\_

**List any medications, including vitamins and supplements used at the current time:**

\_\_\_\_\_

\_\_\_\_\_

**SUBSEQUENT/OTHER PROFESSIONAL CARE**

WHAT TYPES OF PROFESSIONAL CARE HAVE YOU RECEIVED OR ARE YOU CURRENTLY RECEIVING?

Physicians Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Physiatrist Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Neurologist Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Neurologist Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Physical Therapist Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Speech / Language Therapist Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Psychologist / Psychiatrist Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Osteopathic Physicians Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Occupational Therapist Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Do you have a history of allergies?  Yes  No  
 If yes, please explain: \_\_\_\_\_  
 Has a neurological evaluation been performed?  Yes  No  
 If yes, by whom? \_\_\_\_\_ Date: \_\_\_\_\_  
 Results: \_\_\_\_\_  
 Has a psychological evaluation been performed?  Yes  No  
 If yes, by whom? \_\_\_\_\_  
 Results: \_\_\_\_\_  
 Has a speech and language evaluation been performed?  Yes  No  
 If yes, by whom? \_\_\_\_\_ Date: \_\_\_\_\_  
 Results: \_\_\_\_\_

**MEDICAL HISTORY**

Is there any history of the following? (Please check if there is a history)

|                     | <u>Patient</u>           | <u>Family</u>            | <u>Who</u> |                        | <u>Patient</u>           | <u>Family</u>            | <u>Who</u> |
|---------------------|--------------------------|--------------------------|------------|------------------------|--------------------------|--------------------------|------------|
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | _____      | Glaucoma               | <input type="checkbox"/> | <input type="checkbox"/> | _____      |
| Diabetes            | <input type="checkbox"/> | <input type="checkbox"/> | _____      | Cataracts              | <input type="checkbox"/> | <input type="checkbox"/> | _____      |
| Thyroid condition   | <input type="checkbox"/> | <input type="checkbox"/> | _____      | Blindness              | <input type="checkbox"/> | <input type="checkbox"/> | _____      |
| Multiple Sclerosis  | <input type="checkbox"/> | <input type="checkbox"/> | _____      | Strabismus             | <input type="checkbox"/> | <input type="checkbox"/> | _____      |
| Brain Tumor         | <input type="checkbox"/> | <input type="checkbox"/> | _____      | Amblyopia              | <input type="checkbox"/> | <input type="checkbox"/> | _____      |
| Stroke              | <input type="checkbox"/> | <input type="checkbox"/> | _____      | Traumatic brain injury | <input type="checkbox"/> | <input type="checkbox"/> | _____      |

**VISUAL HISTORY**

Have you had a previous vision evaluation: Yes No

If yes, doctor's name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Reason for examination: \_\_\_\_\_

Were glasses, contact lenses or other optical devices recommended? Yes No

If yes, what? \_\_\_\_\_

Are they used? Yes No If yes, when? \_\_\_\_\_

If no, why not? \_\_\_\_\_

Were any additional tests, treatments, or therapies recommended concerning your vision? Yes No

If yes, what? \_\_\_\_\_

Did you undergo these treatments? Yes No Explain: \_\_\_\_\_

Results and Recommendations: \_\_\_\_\_

**DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING:**

|                                       | <u>Yes</u>               | <u>No</u>                | <u>Prior to Injury?</u>  |
|---------------------------------------|--------------------------|--------------------------|--------------------------|
| Eyes ache                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty moving or turning eyes     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain with movement of eyes            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eyes twitch                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain in or around eyes                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye redness                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Burning eyes                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Watery eyes                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Itchy eyes                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Brightness is bothersome              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Motion sickness / car sickness        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Headaches                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blurred vision                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty changing focus far to near | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

|   | <u>Yes</u>               | <u>No</u>                | <u>Prior to Injury?</u>  |
|---|--------------------------|--------------------------|--------------------------|
| Double Vision   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| One eye turns in, out, up or down                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Movement of objects is bothersome                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Patterned wallpaper or carpets<br>are bothersome        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Head moves when reading                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lose place often when reading                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Words jump or move around when reading                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Short attention span for reading or writing             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Skip words frequently when reading                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Discomfort when reading                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of interest/concentration when<br>doing close work | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty writing/drawing on page                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Squinting, covering or closing one eye                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Head tilts during deskwork                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hold books too close when writing                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty with peripheral vision                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Objects jump in and out of field of view                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reduced depth perception                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tunnel vision/Loss of visual field                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Flashes of light  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty following a series of directions             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty using both sides of the<br>body together     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

|                            | <u>Yes</u>               | <u>No</u>                | <u>Prior to Injury?</u>  |
|----------------------------|--------------------------|--------------------------|--------------------------|
| Awkward, poor balance      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizziness                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Confusion / disorientation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- Difficulty remembering things seen
- Difficulty remembering names or words
- Difficulty with numbers
- Dislike heights

Why do you feel the need for a vision evaluation? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**LIFESTYLE**

Do you feel your vision interferes with activities of daily living? Yes No

If yes, please explain (please include effects involving home, work, hobbies social and personal relationships):

\_\_\_\_\_  
 \_\_\_\_\_

What activities can you no longer engage in due to your visual or other difficulties? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

What other changes/limitations in your daily life do you attribute to your accident/injury? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

What do you hope a Visual Rehabilitation Program can do for you? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

**EMPLOYMENT/EDUCATION INFORMATION (IF APPLICABLE)**

What is your current employment position? \_\_\_\_\_

If a student, what is the major course of study? \_\_\_\_\_

How many hours daily are spent at a desk or near activities? \_\_\_\_\_

How many hours daily are spent on a computer? \_\_\_\_\_

**Release of Information and Insurance Filing:**

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

I authorize the release of medical information to other health care providers or insurance carriers upon their written request, or upon the recommendation of *Domiano Eye Care Center* when it is necessary for the treatment of my visual condition or for the processing of insurance claims. This authorization shall be considered valid for the duration of my treatment.

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Signature of patient or authorized representative

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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 evaluation and to better meet your specific visual needs.

If at any time you have any questions or concerns regarding your vision or treatment, please do not hesitate to contact us.

We request a minimum of 24 hours notice if you are unable to keep this appointment.

Please be on time for your evaluation so that we may have the maximum opportunity to evaluate your visual status. Your visit can take from one (1) hour to (2) two hours.

**Payment for Services:**

Our office cannot provide you with information regarding the extent of coverage by your insurance company. All we can do is get an estimate based on information that we gather from you and/or your insurance company's website. We are out-of-network for most major medical carriers. Please be prepared to pay for your services and materials at the time of your visit. If you have any questions, please contact our office.