

VISION DEVELOPMENT INSTITUTE

Towne Centre Offices, 1789 S. Braddock Ave Pittsburgh PA 15218

Phone (412) 731-5007 FAX (412) 731-5251

Date _____

Please fill out the following history questionnaire as best as possible. This information allows maximum use of your office time, and assists us in determination of appropriate examination routines most applicable to your situation.

Name _____

Address _____

Phone # _____

City _____, State _____ Zipcode _____

Sex _____

Birthdate _____

Age Now _____

Work # _____

Insurance _____

I.D. # _____

Group # _____

Who referred you? _____

Specific reason for referral? _____

What do you hope to find out from the exam? _____

EDUCATION

High School Attended _____

Location _____

College Attended _____

Location _____

Dates _____

Degree _____

College Attended _____

Location _____

Dates _____

Degree _____

Did you like school? _____

Was your attendance regular? _____

Were you ever retained? _____

If yes, in what grade? _____

What was your reaction to being retained? _____

Did you like some subjects better than others? _____

List favorite subjects: _____

subjects disliked? _____

Did you receive any special help in school, tutoring, etc? _____

Rate your performance in the following areas:

Reading Comprehension	Expressing thoughts verbally
Reading Rate	Expressing thoughts written
Reading Retention	Math Concepts
Spelling	Attention Span
Handwriting	Ability to follow written directions
	Ability to follow spoken directions

In school, did you mostly
Memorize answers Think through a problem when required

Do you wish to obtain further education?

JOB INFORMATION

Employer
Type of work
Job title
Amount of reading required on job
Type of reading required for your job
Type of materials you find difficult to read
Does job require much writing?
Amount of computer work on the job
Any difficulties experienced at work
If yes, describe in detail:

MEDICAL HISTORY

List any serious accidents, operations, or unusual or confining illness. Where possible, give dates.

State any existent allergies:
Date of last Physical Exam:
State chronic physical problems:
Current medication(s):
Any neurological exam?
Reason for such exam?
Recommendations?
Any counseling received?
Reason for counseling?
Was counseling successful?

Other pertinent medical history

VISUAL HISTORY

When and by whom has there been previous visual care?

Date	Doctor
Date	Doctor

Were glasses prescribed? _____

Headaches? _____ When? _____

Blurred Vision or "sting" _____ When? _____

Eyes seem "tired" _____ When? _____

Seeing "double" _____ When? _____

Blurred vision at near? _____ At distance? _____

Do bright lights bother you? _____

Are eyes bloodshot frequently? _____ Frequent blinking? _____

Difficulty changing fixation? _____ Lose focus when reading? _____

Lose place when reading? _____ Do you like to read? _____

How much do you read? _____

Ever reverse words or letters in reading or spelling? _____

Skip words or re-read passages? _____

Hold book too-close while reading? _____

PERSONAL INTERESTS

What special interests or hobbies? _____

What do you do in leisure time? _____

Team sports in which you participate? _____

Individual sports? _____

Time per day spent watching TV? _____

Kind of reading done in last month? _____

Any difficulties in work relationships? _____

Any difficulties in social relationships? _____

PREVIOUS EVALUATION

Type of testing: _____

Administered by: _____

Date: _____ Findings: _____

Type of testing: _____

Administered by: _____

Date: _____ Findings: _____

Additional information about yourself that you deem important for us to know:

Signature of person completing this history form: _____