

VISION DEVELOPMENT INSTITUTE

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

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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	Occupation		
Address			
City	State	Zip	Phone #
	Birthdate	Age Now	Work #
Insurance	I.D. #	Group #	

A: Present Situation:

1. In what way do you seem to have visual difficulty?

2. Do you have any of the following, and if so, when? (circle yes or no)

a. Headaches:	Yes	No	When?
b. Blurred Vision:	Yes	No	When?
c. Double Vision:	Yes	No	When?
d. Eyes "hurt or tired"	Yes	No	When?

B: Have you or anyone else ever noted the following, and if so, when? (circle yes or no)

1. Holding reading close?	Yes	No	When?
2. Closing one eye?	Yes	No	When?
3. Covering one eye?	Yes	No	When?
4. Eyes frequently bloodshot?	Yes	No	When?
5. Frequent Styes?	Yes	No	When?
6. Excessive eye rubbing	Yes	No	When?
7. Excessive blinking?	Yes	No	When?
8. Getting lost in book: (not aware of surroundings)?		Yes	No When?
9. Tilting head when reading	Yes	No	When?
10. Reading in bed?	Yes	No	When?
11. Inability to see distant objects?	Yes	No	When?
12. Bumping into objects?	Yes	No	When?
13. Poor general coordination?	Yes	No	When?
14. Large pupils in normal light?	Yes	No	When?
15. Bothered by light?	Yes	No	When?
16. Are you fatigued frequently?	Yes	No	When?
17. Are you easily irritated?	Yes	No	When?

C: School / Employment (circle yes or no, good average or poor)

1. Age at time of entrance to First Grade?	Did you like school?	Yes	No			
2. Has a grade ever been repeated?	Yes	No	Was your school work?	Good	Average	Poor
3. Explain any school difficulties:						
4. List subject(s) which seem particularly easy for you:						
5. List subject(s) which seem particularly hard for you:						
6. How is your job performance?			Good	Average	Poor	
7. Do you feel your job performance could be better?			A lot	Some	None	

D: Developmental History

1. At what age did you first walk?
2. List past and present illnesses:

E: Visual History:

1. How long has difficulty been noticed?
2. Previous visual examinations:

Date	Doctor's Name	Results
3. Members of your family who have had visual attention and why?

Name	Age	Visual Situation

As you complete this history questionnaire, you will recognize the thoroughness with which your problem will be considered. The office examination will take up enough time to permit a very complete optometric investigation of the problem. Your future deserves the fullest consideration that you and we here in the office can provide.

Thank You,

Present Date _____

Hans F. Lessmann, O.D.
Developmental Optometrist