VISUAL HEALTH & LEARNING CENTER

Dr. Jenna Williams McDermed

Date_____

Name_____Age_____DOB_____

Address_____

City_____ Zip_____ Email _____

Home Phone ( ) _____ Cell Phone ( ) _____

Person responsible for account_____ Relationship_____

Employer_____ Work Phone_____

Emergency Contact_____ Phone ( ) _____

How did you hear about us? _____

Date of last eye examination_____ Have you ever had Vision Therapy? ☐Yes ☐ No

Do you currently use vision correction? ☐ None ☐ Glasses ☐ Bifocals ☐ Contacts

If you wear glasses, why? ☐ Distance only ☐ Near only ☐ Full-time ☐ Computer only

Have you ever had eye surgery? ☐Yes ☐ No

If yes, when & why? _____

What is the main reason for your visit today? _____

_____

Are you restricted from any activities you enjoy due to your vision? _____

Health History:

Do you use tobacco? ☐Yes ☐ No Do you regularly consume alcohol? ☐Yes ☐ No How much?_____

Are you regularly taking pills or medications ☐Yes ☐ No Specify _____

Last physical date_____How is your general health? ☐ Excellent ☐ Good ☐Fair ☐ Poor

List any allergies to any medications:_____

Please check all conditions that apply to you or that run in your family:

Allergies	☐ Self	☐ Family	**Lazy Eye**	☐ Self	☐ Family
Respiratory disease	☐ Self	☐ Family	**Turned Eye**	☐ Self	☐ Family
Drug Sensitive	☐ Self	☐Family	**Glaucoma**	☐ Self	☐ Family
Cancer	☐ Self	☐Family	**Dry eyes**	☐ Self	☐ Family
Diabetes	☐ Self	☐Family	**Eyestrain**	☐ Self	☐ Family
Thyroid	☐ Self	☐ Family	**Light sensitive**	☐ Self	☐ Family
Heart problem	☐ Self	☐ Family	**Floaters/spots**	☐ Self	☐ Family
High blood pressure	☐ Self	☐ Family	**Flashing lights**	☐ Self	☐ Family
Head trauma	☐ Self	☐ Family	**Blindness**	☐ Self	☐ Family
Migraines	☐ Self	☐ Family	**Cataracts**	☐ Self	☐ Family
Retinal detachment	☐ Self	☐ Family	**Color "blind"**	☐ Self	☐ Family
Macular Degeneration	☐ Self	☐ Family	**Eye Injury**	☐ Self	☐ Family

Occupational History:

What is your occupation? _____

Job duties _____

Hours per day spent reading or doing close work? _____

Do you use a computer? ☐Yes ☐ No Do you have any problems seeing the monitor? ☐Yes ☐ No

Do you experience any back or neck pain? ☐Yes ☐ No

Do you experience any of the following discomforts at work or home?

☐Eye strain ☐Get sleepy ☐Letters blur as you read ☐Lose your place often

☐See double ☐Pulling sensation near eyes ☐ Car or Motion Sickness

Do you avoid certain tasks? ☐Yes ☐ No If yes, explain _____

Does it take more effort to see clearly as the day goes on? ☐Yes ☐ No

When computing, do your eyes get ☐red ☐dry ☐ache ☐sore

Do letters ever "swim"? ☐Yes ☐ No

Does any lighting ever bother you? ☐Yes ☐ No

Do reflections or glare ever bother you? ☐Yes ☐ No

Is it hard to proofread or find errors? ☐Yes ☐ No

Please check the recreational activities in which you participate:

☐Swimming ☐Soccer ☐Football ☐Tennis ☐Racquetball ☐ TV Viewing ☐Bike riding

☐Gardening ☐Home workshop ☐Golf ☐Hunting/shooting ☐Music ☐Card Playing ☐Crafts

☐Basketball ☐Diving ☐Sewing ☐Baseball ☐Video Games ☐Other (specify)_____

Have you noticed any of the following? Please check (√) all areas of concern

	NEVER	ONCE IN A WHILE	SOMETIMES	A LOT	ALWAYS
Headaches with near work					
Words run together reading					
Burn, Itch, Watery eyes					
Skips/Repeats lines reading					
Head tilt/ Close one eye when reading					
Difficulty copying from chalkboard					
Avoids near work/reading					
Omits small words when reading					
Writes up/down hill					
Misaligns digits/columns numbers					
Reading comprehension down					
Holds reading too close					
Trouble keeping attention on reading					
Difficult completing assignments on time					
Always says "I can't" before trying					
Clumsy, knocks things over					
Does not use his/her time well					
Loses belongings/things					
Forgetful/poor memory					

XO_____ X1_____ X2_____ X3_____ X4_____

TOTAL SCORE_____

Name_____

Dilation Consent

Florida Board of Optometry & the American Optometric Association recommend a dilated eye examination to fully assess the health of your eyes. Without dilation, a condition with the potential for the partial or total loss of vision may exist & go undetected. Dilation is part of a complete eye examination and does not cost extra.

Dilation will cause sensitivity to light & will make your near vision blurry temporarily. Our office will provide you with disposable sunglasses to minimize you sensitivity. If you have any questions, the Doctor will be happy to discuss dilation with you.

☐ **Yes, I want my eyes dilated today.**
☐ **No, I do not want my eyes dilated today, but I will reschedule the dilation.**
☐ **No, I choose not to have my eyes dilated.**

Acknowledgement of Receipt of Privacy Practices

I acknowledge that I have received or had access to a copy of the privacy practices at the Visual Health & Learning Center.

Signed_____Date _____

Authorization of Treatment

I authorize myself to be examined and treated. I understand that the Visual Health & Learning Center is an Out-of-Network Provider for all Insurance Companies. Therefore, payment is required at the date of service. I am responsible to pay for services and hereby authorize release of pertinent information to insurance carriers for reimbursement directly to the patient.

Signed_____Date _____