1605 ROCK PRAIRIE ROAD SUITE 214
COLLEGE STATION, TX 77845
979.541.APEX (2739)
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ADULT QUESTIONNAIRE

Please fill out this questionnaire carefully and return it to our office 24 hours prior to your appointment. Thank you.

Appointment Type: _____ Date: _____ Time: _____

GENERAL INFORMATION

Full Name: _____ Male ☐ Female ☐

Birth Date: _____ Age: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

REFERALS AND REPORTS

Were you referred to our office? Yes ☐ No ☐

If yes, whom may we thank for this referral? _____ Phone: _____

Address _____

Please list any individuals who you would like a report sent:

Name	Business Name	Address	Phone

VISUAL HISTORY

What is the main reason for today's visit?

_____

How long has this problem/difficulty been observed? _____

Are you here for a second opinion regarding surgery or treatment? Yes ☐ No ☐

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If therapy is recommended, what are your goals?

_____

_____

_____

_____

_____

Previously Diagnosed Conditions

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

	Self	Family	Comments
Amblyopia (Lazy Eye)	☐	☐	
Blindness	☐	☐	
Cataract	☐	☐	
Diabetes in Eye	☐	☐	
Eye Injury	☐	☐	
Eye Surgery	☐	☐	
Glaucoma	☐	☐	
Macular Disease	☐	☐	
Retinal Disease	☐	☐	
Strabismus (Eye Turn)	☐	☐	
None of the Above	☐	☐	

Other _____

Strabismus (Eye Turn) History (if applicable)

Which eye turns? ☐ Both ☐ Left ☐ Right

Which direction does it turn? ☐ In ☐ Out ☐ Up ☐ Down

How often does it turn? ☐ Always ☐ Intermittently

Did it begin gradually or suddenly? ☐ Gradually ☐ Suddenly

How is it changing? ☐ Better ☐ Worse ☐ No change

Under what circumstances does it turn?

_____

_____

_____

Did it result from a disease, trauma, etc? ☐ Yes ☐ No

If yes, please explain:

_____

_____

_____

Does it turn less when glasses are worn? ☐ Yes ☐ No

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Eye Evaluation History:

Date of Last Evaluation: _____

Name of Eye Doctor:_____

Doctor's Phone #: _____

Doctor's Address: _____

Results and recommendations: _____

Eyewear History

What is your primary type of eyewear? ☐ Glasses ☐ Contacts ☐ None

If glasses, what type? ☐ Single vision ☐ Bifocal ☐ Trifocal ☐ Progressive

When are they worn, or if not, why not? _____

Patching History

Has there been any treatment using an eye patch? Yes ☐ No ☐

If yes, please describe when the patching was started, how the patching was done, including the age it started, the eye patched, the duration of treatment, and an estimate of the results: _____

_____

Surgery

Has there been any surgical treatment? Yes ☐ No ☐

Doctor's Name: _____ Phone:_____

Address: _____

If yes, please describe the surgery, including the age surgery was performed, the number of operations, the eye(s) operated on, and an estimate of the cosmetic and subjective results: _____

_____

If yes, was the surgeon satisfied with the results of surgery? Yes ☐ No ☐ Explain: _____

_____

If yes, were you satisfied with the results of surgery? Yes ☐ No ☐ Explain: _____

_____

If yes, have surgical results been maintained? Yes ☐ No ☐

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Vision Therapy

Has there been any visual therapy? Yes ☐ No ☐

Doctor's Name: _____ Phone:_____

Address:_____

If yes, please describe the type of visual therapy, including duration, the age at which it started and an estimate of results:

_____

_____

Current Visual Symptoms

Please check your symptoms and write how frequently they occur: 0=Never, 1=Seldom, 2= Occasionally, 3 = Frequently, 4= Always

Refractive Status & Focusing Symptoms	Yes	No	How frequently (0 through 4)?
Blurred distance vision	☐	☐	
Blurred near vision	☐	☐	
Vision is worse at end of the day	☐	☐	
Headaches	☐	☐	
Eyes hurt or are tired after near work	☐	☐	
Avoids reading or other near tasks	☐	☐	
Lag in focus	☐	☐	

Oculomotor Symptoms	Yes	No	How frequently (0 through 4)?
Moves head when writing or reading	☐	☐	
Skips or repeats lines when reading	☐	☐	
Loss of place when reading	☐	☐	
Uses a finger to keep place	☐	☐	

Eye Teaming (Binocularity) Symptoms	Yes	No	How frequently (0 through 4)?
Closes or covers eye to see better	☐	☐	
Tilts head	☐	☐	
Reads slowly	☐	☐	
Double vision	☐	☐	
Words move around on the page	☐	☐	
Words run together when reading	☐	☐	
Car or motion sickness	☐	☐	
Poor reading comprehension	☐	☐	
Does not judge distance accurately	☐	☐	

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Eye-Hand Coordination Symptoms	Yes	No	How frequently (0 through 4)?
Poor/awkward general motor coordination	☐	☐	
Poor/awkward fine motor coordination	☐	☐	
Clumsy, knocks things over	☐	☐	
Poor/inconsistent in sports	☐	☐	
Writes or prints poorly	☐	☐	
Misaligns digits in a column of numbers	☐	☐	
Writes up/down hill	☐	☐	

Visual Perceptual Symptoms	Yes	No	How frequently (0 through 4)?
Confusion of letters or words	☐	☐	
Reverses letters or words	☐	☐	
Forgetful/poor memory	☐	☐	
Misplaces belongings	☐	☐	
Difficulty attending to details	☐	☐	

Other Visual Symptoms/Concerns	Yes	No	How frequently (0 through 4)?
Difficulty completing assignments on time	☐	☐	
Gives up easily	☐	☐	
Light sensitivity	☐	☐	
Dizziness	☐	☐	

List any other complaints you have concerning vision: _____

Do you feel your vision interferes with your daily activities in any way? Yes ☐ No ☐

If yes, please explain: _____

_____

Medical History

Current state of health (explain): _____

Primary Care Doctor Information

Primary Care Doctor's Name: _____ Phone: _____

Address: _____

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Previously Diagnosed Conditions:

	Self	Family	When Diagnosed/Who		Self	Family	When Diagnosed/Who
ADHD	☐	☐	_____	High blood Pressure	☐	☐	_____
Arthritis	☐	☐	_____	HIV	☐	☐	_____
Chromosomal Disorder	☐	☐	_____	Kidney Disease	☐	☐	_____
Cancer	☐	☐	_____	Learning Disability	☐	☐	_____
Diabetes	☐	☐	_____	Lupus	☐	☐	_____
Dyslexia	☐	☐	_____	Thyroid	☐	☐	_____
Epilepsy/Seizures	☐	☐	_____	None of the Above	☐	☐	_____
Heart Disease	☐	☐	_____	Other: _____			

Medications

List any medications, vitamins, and supplements:

Medication Name	For What Condition
_____	_____
_____	_____
_____	_____
_____	_____

Allergies

List all allergies and your reaction to them.

Allergen	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

Significant Illnesses, Trauma, Surgeries

List any significant illness, head injuries, surgical procedures, falls, etc.

Event	Age	Severity (mild/moderate/severe)	Complications
_____			
_____			
_____			
_____			
_____			

Specialty Testing

Please check off and elaborate if you've received any of the following:

☐ Neurological evaluation? By whom? _____ Phone:_____

Address: _____

Results: _____

☐ Psychological evaluation? By whom? _____ Phone: _____

Address: _____

Results: _____

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☐ Occupational therapy evaluation? By whom? _____Phone:_____

Address: _____

Results: _____

☐ Physical therapy evaluation? By whom? _____ Phone:_____

Address: _____

Results: _____

☐ Speech/hearing therapy evaluation? By whom? _____Phone:_____

Address: _____

Results: _____

☐ Educational testing? By whom? _____ Phone:_____

Address: _____

Results: _____

DEVELOPMENTAL HISTORY

Were you born full-term? Yes ☐ No ☐

Did your mother experience any problems while pregnant with you? Yes ☐ No ☐

If yes, explain: _____

Any complications before, during or immediately following delivery? Yes ☐ No ☐

If yes, explain: _____

Were there ever any concerns about your growth or development? Yes ☐ No ☐

If yes, explain: _____

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EMPLOYMENT OR SCHOOL

General Information

Current Status: ☐ Full Time Student ☐ Part Time Student ☐ Full Time Employment ☐ Part Time Employment ☐ Retired

Current position: _____

Describe briefly your daily activities at work or in school:

_____

_____

_____

Please list any specific tasks that you find challenging:

_____

_____

_____

Are you achieving up to your potential at work or school? Yes ☐ No ☐

Do you feel you are getting adequate return for the amount of effort you put into a task? Yes ☐ No ☐

Computer Use

How many hours do you spend looking at electronic screens each day? _____

How many hours do you spend reading or studying printed material each day? _____

Do you wear glasses or contacts while at the computer? Yes ☐ No ☐

How do your eyes feel after working at the computer? _____

Academics

Please answer the following if you are in an academic program:

Major course of study: _____ Overall academic performance is: ☐ Poor ☐ Average ☐Great

Have you received any specialist tutoring or remedial assistance? Yes ☐ No ☐ How long it did last? _____

If yes, where and who did you receive assistance from? _____

If yes, describe the type and frequency of assistance: _____

If yes, what were the results of the assistance? _____

Please list subjects where your performance is above average: _____

Please list subjects where your performance is average: _____

Please list subjects where your performance is below average: _____

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HOBBIES/LEISURE TIME

Describe the types of activities that comprise the majority of your spare time: _____

_____

_____

Are there activities that you'd like to participate in but don't? Yes ☐ No ☐ If yes, which activities and why not?

_____

_____

Do you like to read? Yes ☐ No ☐ If yes, what do you like to read? _____

How many hours a week do you watch TV? _____

Sports

Are you seriously involved with athletics? Yes ☐ No ☐ If yes, please fill out the chart below:

Sport	Level/Division/League	Position	Performance (poor, average, excel)	Check if you'd like to improve
				☐
				☐
				☐
				☐
				☐

Do you feel you are achieving up to your potential in athletics? Yes ☐ No ☐ If no, why not?

_____

_____

HOME AND FAMILY LIFE

Please list everyone you live with, their relation to you, and their birthday.

Name	Relation	Birthday

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Give a brief description of yourself as a person.

_____

_____

_____

Is there any other information that you feel would be helpful / important in our evaluation and/or treatment? Yes ☐ No ☐

If yes, explain: _____

_____

_____

_____

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RELEASE OF INFORMATION

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

I agree to permit information from, or copies of, my examination records to be forwarded to other health care providers or insurance carriers upon their written request or upon the recommendation of Apex Performance Vision when it is necessary for the treatment of my visual condition, or for the processing of insurance claims. I authorize Dr. Lisa Januskey, OD and Apex Performance Vision to exchange information with my school, employer, and other professionals involved in my care by means of my signature below. This authorization shall be considered valid throughout the duration of treatment. I hereby give my permission to the Apex Performance Vision to treat me:

_____ _____
Patient's Signature Date

_____
Patient's Printed Name

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Thank You!

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to better understand and meet your child's specific visual needs. **This questionnaire must be submitted by the Friday before your appointment or your visit will be cancelled.** It is important for our doctor to review your questionnaire prior to your appointment to be able to follow up with additional questions during your appointment time.

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us. You may leave a message for us 24 hours a day / 7 days a week. We request a minimum of 24 hours notice if you are unable to keep this appointment. **Failure to submit the questionnaire before the deadline or provide 24 hours notice of cancellation will result the forfeiture of your deposit.**

Please be on time for your examination so that we will have the maximum opportunity to evaluate your visual status. Failure to arrive on time may prevent the doctor from being able to complete the evaluation. **Additional appointment slots needed to complete the evaluation will result in additional fees.**

Please make sure that you are well rested and fed before the appointment, turn off your cell phone, and leave anything or anyone that you feel may be distracting at home so that we can have your undivided attention during the evaluation.

THANK YOU.

Sincerely,

Dr. Lisa Januskey, OD

Dr. Lisa Januskey, OD
Developmental Optometrist