DR. ELISE BRISCO, O.D.

HOLLYWOOD VISION CENTER-OPTOMETRY
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Scleral Contact Lenses
MoisturEyes Dry Eye
Vision Therapy
Children's Vision
Rehabilitation Vision

VISION REHABILITATION QUESTIONNAIRE

Please fill out this questionnaire carefully. Please return it to our office prior to your appointment via email: hollywoodvisioncenter@totalvisionllc.com ***THANK YOU***

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 ☐ Sports Injury to head
☐ 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 ☐ Difficulty Talking
☐ 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:_____

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

Please check if there any history of the following:

	Patient	Family	Who		Patient	Family	Who
High blood pressure	☐	☐	___	Glaucoma	☐	☐	___
Diabetes	☐	☐	___	Cataracts	☐	☐	___
Thyroid condition	☐	☐	___	Blindness	☐	☐	___
Multiple Sclerosis	☐	☐	___	Strabismus	☐	☐	___
Brain Tumor	☐	☐	___	Amblyopia	☐	☐	___
Stroke	☐	☐	___	Traumatic brain injury	☐	☐	___

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:

	Yes	No	Prior to Injury?
Eye ache	☐	☐	☐
Difficulty moving or turning eyes	☐	☐	☐

Pain with movement of eyes	☐	☐	☐
Eyes twitch	☐	☐	☐
Pain in or around eyes	☐	☐	☐
Eye redness	☐	☐	☐
Burning eyes	☐	☐	☐
	Yes	**No**	**Prior to Injury?**
Watery eyes	☐	☐	☐
Itchy eyes	☐	☐	☐
Brightness is bothersome	☐	☐	☐
Motion sickness / car sickness	☐	☐	☐
Headaches	☐	☐	☐
Blurred vision	☐	☐	☐
Difficulty changing focus far to near	☐	☐	☐
Double Vision	☐	☐	☐
One eye turns in, out, up or down	☐	☐	☐
Movement of objects is bothersome	☐	☐	☐
Patterned wallpaper or carpets are bothersome	☐	☐	☐
Head moves when reading	☐	☐	☐
Lose place often when reading	☐	☐	☐
Words jump or move around when reading	☐	☐	☐
Short attention span for reading or writing	☐	☐	☐
Skip words frequently when reading	☐	☐	☐
Discomfort when reading	☐	☐	☐
Loss of interest/concentration when doing close work	☐	☐	☐
Difficulty writing/drawing on page	☐	☐	☐
Squinting, covering or closing one eye	☐	☐	☐
Head tilts during deskwork	☐	☐	☐
Hold books too close when writing	☐	☐	☐
Difficulty with peripheral vision	☐	☐	☐
Objects jump in and out of field of view	☐	☐	☐
Reduced depth perception	☐	☐	☐
Tunnel vision/Loss of visual field	☐	☐	☐

Flashes of light	☐	☐	☐
Difficulty following a series of directions	☐	☐	☐
Awkward, poor balance	☐	☐	☐
Dizziness	☐	☐	☐
Confusion / disorientation	☐	☐	☐
Difficulty remembering things seen	☐	☐	☐
Difficulty remembering names or words	☐	☐	☐
Difficulty with numbers	☐	☐	☐
Dislike heights	☐	☐	☐
Difficulty using both sides of the body together	☐	☐	☐

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 *the Hollywood Vision Center - Optometry* 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.

_____ _____

Signature of patient or authorized representative 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 48 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. Please bring your neurologist's report, neuro-psychologist evaluation, a list of your medications, and all your glasses or their written prescriptions.

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.

Sincerely,

Elise Brisco, OD, CCH, FAAO, FCOVD