Panorama OPTOMETRY

111 - 15161 Hwy 10, Surrey, BC V3S 9A5

Office | 604.576.6588
Fax | 604.576.7988
Email | info@panoramaoptometry.com
www.panoramaoptometry.com

VISION REHABILITATION QUESTIONNAIRE

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

Appointment: Date: _____ Time: _____

GENERAL INFORMATION

Full Legal Name: _____ ☐ Male ☐ Female
Birth Date: _____
Home Address: _____
Home Phone: _____Mobile Phone: _____Work Phone:_____
Email address: _____Care Card Number:_____
What is your occupation?_____
Are you currently working? _____

Were you referred to our office? ☐ Yes ☐ No
If yes, whom may we thank for this referral? _____Profession: _____

MEDICAL HISTORY

Last Medical Checkup:_____ Name of Family Physician:_____
List of Current Medications and Supplements: _____
_____
_____
_____
Do you have any allergies? If so, please list: _____
_____

Date of injury/accident: _____
What was involved in the injury/accident?_____
_____
_____
_____

Did you lose consciousness? If yes, for how long:_____

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TREATMENT

What types of professional care have you received or are currently receiving? Please list the professionals name and current recommendations.

Physiotherapy_____
_____

Occupational therapy_____
Massage therapy_____
_____

Neuropsychologist_____
_____

Audiologist_____
_____

Other_____
_____
_____

MEDICAL HISTORY
Have you or anyone in your family been treated for any of the following conditions:

	Patient	Family	Whom
High blood pressure	☐	☐	_____
Diabetes	☐	☐	_____
Heart Condition	☐	☐	_____
Stroke	☐	☐	_____
Cholesterol	☐	☐	_____
Thyroid Condition	☐	☐	_____
Cancer	☐	☐	_____
Glaucoma	☐	☐	_____
Cataracts	☐	☐	_____
Macular Degeneration	☐	☐	_____
Blindness	☐	☐	_____
Strabismus	☐	☐	_____
Amblyopia	☐	☐	_____

Other personal or family medical history: _____
_____
_____
_____

Do you smoke? ☐ Yes ☐ No If yes, how much?_____
Do you drink? ☐ Yes ☐ No If yes, how much?_____

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VISUAL HISTORY

When was your last eye examination? _____Doctors Name:_____
Do you wear glasses or contact lenses?_____
Have you ever had any eye injuries? If yes, what happened and when:_____
_____
Have you ever had any eye surgeries? If yes, what type of surgery and when: _____
_____

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING (Please circle all that apply):

☐ Double Vision	☐ Vomiting	☐ Flashes of Light	☐ Headache	☐ Restricted motion
☐ Disorientation	☐ Memory Loss	☐ Blurred Vision	☐ Pain in/around eyes	
☐ Loss of balance	☐ Light Sensitivity	☐ Dizziness	☐ Restricted field of view	
☐ Motion sickness	☐ Neck pain/whiplash			

Other: _____
_____
_____
_____

FINANCIAL POLICY

We require payment at the time of the appointment and we will provide a receipt for reimbursement submission.

BIVSS CHECKLIST (Brain Injury Vision Symptom Survey)

Patient Name: _____ Today's date: _____

My brain injury was: ____ years ago My age is: ____ years today's date: _____

☐ I have had a medical diagnosis of brain injury (check box if true) Cause of injury: _____

☐ I sustained a brain injury without medical diagnosis (check box if true) _____

☐ I have NOT ever sustained a brain injury (check box if true)

Please check the most appropriate box, or circle the item number that best matches your observations. All information will be held in confidence. Thank you for your help!

SYMPTOM CHECKLIST ***Circle a number below:***

Please rate each behavior. **How often does each behavior occur?** (circle a number)	Never	Seldom	Occasionally	Frequently	Always
EYESIGHT CLARITY					
Distance vision blurred and not clear -- even with lenses	0	1	2	3	4
Near vision blurred and not clear -- even with lenses	0	1	2	3	4
Clarity of vision changes or fluctuates during the day	0	1	2	3	4
Poor night vision / can't see well to drive at night	0	1	2	3	4
VISUAL COMFORT					
Eye discomfort / sore eyes / eyestrain	0	1	2	3	4
Headaches or dizziness after using eyes	0	1	2	3	4
Eye fatigue / very tired after using eyes all day	0	1	2	3	4
Feel "pulling" around the eyes	0	1	2	3	4
DOUBLING					
Double vision -- especially when tired	0	1	2	3	4
Have to close or cover one eye to see clearly	0	1	2	3	4
Print moves in and out of focus when reading	0	1	2	3	4
LIGHT SENSITIVITY					
Normal indoor lighting is uncomfortable – too much glare	0	1	2	3	4
Outdoor light too bright – have to use sunglasses	0	1	2	3	4
Indoors fluorescent lighting is bothersome or annoying	0	1	2	3	4
DRY EYES					
Eyes feel "dry" and sting	0	1	2	3	4
"Stare" into space without blinking	0	1	2	3	4
Have to rub the eyes a lot	0	1	2	3	4
DEPTH PERCEPTION					
Clumsiness / misjudge where objects really are	0	1	2	3	4
Lack of confidence walking / missing steps / stumbling	0	1	2	3	4
Poor handwriting (spacing, size, legibility)	0	1	2	3	4
PERIPHERAL VISION					
Side vision distorted / objects move or change position	0	1	2	3	4
What looks straight ahead--isn't always straight ahead	0	1	2	3	4
Avoid crowds / can't tolerate "visually-busy" places	0	1	2	3	4
READING					
Short attention span / easily distracted when reading	0	1	2	3	4
Difficulty / slowness with reading and writing	0	1	2	3	4
Poor reading comprehension / can't remember what was read	0	1	2	3	4
Confusion of words / skip words during reading	0	1	2	3	4
Lose place / have to use finger not to lose place when reading	0	1	2	3	4