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.