5012 Dorsey Hall Drive, Suite 105
Ellicott City, Maryland 21042
www.ellicottcityeyes.com
(410) 730-8878

Name: ______________________ DOB: __________ Present Age: __________
Address: ______________________ City: __________ State: ______ Zip: ________
Home Phone: __________________ Business Phone: ______________ Cell Phone: ______________
Occupation: __________________ Referred by: ______________ Email: ______________
What do you expect to find out from the evaluation? ______________________________

How did you perform in school? □ Average □ Above Average □ Below Average
Do you play sports? □ Yes □ No Type & Amount: ______________________________
Other Form of exercise: ______________________________
Do you have any hobbies? ______________________________
How many hours per day do you: Use Computer______Read_____Watch TV______ Play Video Games______
Are there activities that you would enjoy doing but must restrict because of your vision? □Yes □ No
Please explain: ______________________________

Present Situation:
In what ways are you having visual difficulty? ______________________________
How long have you noticed this difficulty? ______________________________
Have you been diagnosed with a concussion? □ Yes □ No Date of Injury: ______________

Previous Examinations:

Reason for Evaluation	Doctor's Name	Date	Result

Have you or anyone else noticed an eye turn in or wander out? □ Yes □ No Which Eye? __________
At what age was it first noticed? __________ Have you had eye surgery? □ Yes □ No ____________

Do you ever experience any of the following?

Headaches	□ Yes	□ No	When?_______	Eyes hurt/tired	□ Yes	□ No	When?_______
Blurred vision at far	□ Yes	□ No	When?_______	Double vision	□ Yes	□ No	When?_______
Blurred vision at near	□ Yes	□ No	When?_______	Light Sensitivity	□ Yes	□ No	When?_______

Have you ever noticed the following?

Holding reading material too close	□ Yes	□ No	Difficulty with short term memory	□ Yes	□ No
Holding reading material too far away	□ Yes	□ No	Difficulty with long-term memory	□ Yes	□ No
Tilting head when reading	□ Yes	□ No	Short Attention Span	□ Yes	□ No
Bumping into objects	□ Yes	□ No	Difficulty attenting to details	□ Yes	□ No
Closing one eye when reading	□ Yes	□ No	Difficulty Driving	□ Yes	□ No
Excessive eye rubbing	□ Yes	□ No	Get lost in book/Unaware peripherally	□ Yes	□ No
Experience fatigue quickly when reading	□ Yes	□ No	Avoid sports	□ Yes	□ No
Lose place when reading	□ Yes	□ No	Motion sickness	□ Yes	□ No
Usine finger to keep your place when reading	□ Yes	□ No	Dizzy Spells	□ Yes	□ No

Health/Family History

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

Systemic Disease/Condition

	Yes	No	Relationship
Arthritis	□	□	____________
Rheumatoid arthritis	□	□	____________
Fever	□	□	____________
Weight loss/gain	□	□	____________
Cancer	□	□	____________
Diabetes	□	□	____________
Drug sensitive	□	□	____________
Elevated cholesterol	□	□	____________
Heart disease	□	□	____________
High blood pressure	□	□	____________
Thyroid disease	□	□	____________
Migraine	□	□	____________
Skin (acne, cancer)	□	□	____________
Gastrointestinal	□	□	____________
Urogenital (kidney, bladder)	□	□	____________
Neurological (MS, seizures)	□	□	____________
Psychiatric (depression, etc)	□	□	____________
Allergies	□	□	____________
Respiratory			
asthma	□	□	____________
emphysema	□	□	____________
bronchitis	□	□	____________
Kidney disease	□	□	____________

Ocular Disease/Condition

	Yes	No	Relationship
Lazy eye	□	□	____________
Color "blind"	□	□	____________
Light sensitive	□	□	____________
Eyestrain	□	□	____________
Dry Eyes	□	□	____________
Floaters/Spots	□	□	____________
Flashing light	□	□	____________
Retinal detachment or retinal disease	□	□	____________
Blindness	□	□	____________
Macular degeneration	□	□	____________
Cataracts	□	□	____________
Crossed eyes	□	□	____________
Glaucoma	□	□	____________
Head trauma	□	□	____________
Eye Surgery	□	□	____________

Date of last physical: ____________________________

How is your general health? □ Excellent □ Good □ Fair □ Poor ____

Are you currently under a physician's care? □ Yes □ No

Doctor's name:____

Are you taking any medications? □ Yes □ No

If so, please list: ____

List any major illness:	Age	Mild	Severe
____________________	_______	_______	_______
____________________	_______	_______	_______
____________________	_______	_______	_______
____________________	_______	_______	_______

We are looking forward to meeting you and helping you meet your visual needs.

I authorize the release of medical and/or other information pertinent to my care to the insurance company in order for me to be reimbursed.

Signature: ____ Date:______________