

### 30 Questions Predictive Checklist

Please consider each question and circle the number that best applies to the patient

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_

	Never	Seldom	Occasional	Frequent	Always	Score
Blur When looking at near	0	1	2	3	4	
Double vision, doubled or overlapping words on page	0	1	2	3	4	
Headaches while or after doing near vision work	0	1	2	3	4	
Words appears to run together when reading	0	1	2	3	4	
Burning, itchy or water eyes	0	1	2	3	4	
Falls asleep when reading	0	1	2	3	4	
Seeing and visual work is worse at the end of the day	0	1	2	3	4	
Skips or repeats lines while reading	0	1	2	3	4	
Dizziness or nausea when doing near work	0	1	2	3	4	
Head tilts or one eye is closed or covered while reading	0	1	2	3	4	
Difficulty copying from the chalkboard	0	1	2	3	4	
Avoids doing near vision work such as reading	0	1	2	3	4	
Omits (drops out) small words while reading	0	1	2	3	4	
Write up or down hill	0	1	2	3	4	
Misaligns digits or columns of numbers	0	1	2	3	4	
Reading comprehension low or declines during the day	0	1	2	3	4	
Poor, inconsistent performance in sports	0	1	2	3	4	
Holds books too close, leans too close to computer screen	0	1	2	3	4	
Trouble keeping attention centered on reading	0	1	2	3	4	
Difficulty completing assignments on time	0	1	2	3	4	
First response is "I cannot" before trying	0	1	2	3	4	
Avoids sports and games	0	1	2	3	4	
Poor hand/eye coordination such as poor handwriting	0	1	2	3	4	
Does not judge distance accurately	0	1	2	3	4	
Clumsy, accident prone, knocks things over	0	1	2	3	4	
Does not use or plan his/her time well	0	1	2	3	4	
Does not count or make change well	0	1	2	3	4	
Loses belongings and things	0	1	2	3	4	
Car or motion sickness	0	1	2	3	4	
Forgetful, poor memory	0	1	2	3	4	

20-24 points suspect. 25 points or higher refer for care

Total Score: \_\_\_\_\_

(Please Complete Both Sides)

# Medical History Questionnaire

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_ Marital Status: \_\_\_\_\_

How did you hear about us: \_\_\_\_\_ Email: \_\_\_\_\_

## Medical History

Do you have any allergies to medications?     Yes     No    If yes, please explain: \_\_\_\_\_

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

List all major injuries, surgeries and/or hospitalizations you have had: \_\_\_\_\_

Check any of the following that you have had:

- |  |                                    |  |   |                                     |
|--|------------------------------------|--|---|-------------------------------------|
| <input type="checkbox"/> Crossed Eyes    | <input type="checkbox"/> Lazy Eye  | <input type="checkbox"/> Drooping Eyelid | <input type="checkbox"/> Prominent Eyes | <input type="checkbox"/> Glaucoma   |
| <input type="checkbox"/> Retinal Disease | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Eye Infections  | <input type="checkbox"/> Eye Surgery    | <input type="checkbox"/> Eye Injury |

Are you pregnant and/or nursing     Yes     No

Do you wear glasses?     Yes     No    If yes, how old is your current pair: \_\_\_\_\_

Do you wear contact lenses     Yes     No    If yes, how old is your present pair: \_\_\_\_\_

## Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	Yes	No	?	Relationship to you
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____				_____