OTTAWA VALLEY VISION

Dr. Kristel Jefferies
Ottawa Valley Vision
Ph: 613-633-0734
ottawavalleyvision@gmail.com
ottawavalleyvision.ca

Your Full Name: _____ Date of Birth _____

Address: _____ Current Age _____

City: _____ Prov: _____ Postal Code: _____ Referred by_____

Home Phone: _____ Alternate Phone: _____ Email: ___ _____

Occupation: _____ Do you go to school? ☐Yes ☐No Where, and grade level _____

Did you like school? ☐Yes ☐No Was a grade repeated? ☐Yes ☐No Which grade? ____

Was your work average? ____ better than average? _____ below average?_____

Do you play sports? ☐ Yes ☐ No Type and amount _____

Other forms of exercise _____ Do you have any hobbies? _____

How do you like to spend your free time? _____

How many hours per day do you: ____ use a computer ____read ____watch TV ____play video games

Do you wear contact lenses at this time? ☐Yes ☐No What type? _____

Have you had problems wearing contacts? ☐Yes ☐No Describe _____

Are there any activities you would enjoy doing, but must restrict because of your vision? _____

PRESENT SITUATION: In what ways are you having visual difficulty? _____

_____

_____

How long has your difficulty been noticed? _____

Last visual examination

Reason for exam _____ Date of Exam_____

Doctor's name: _____ Results: _____

List any current medications: _____

_____

Has anyone noticed an eye turn in or wander out? _____Which? _____

Do you ever experience:

Headaches ☐Yes ☐No When? _____ Double Vision ☐Yes ☐No When? _____

Blurred Vision Far ☐Yes ☐No When? _____ Eyes hurt or tired ☐Yes ☐No When? _____

Blurred Vision Near ☐Yes ☐No When? _____

Have you ever noticed the following?

Holding reading close? ☐Yes ☐No When _____ Tilting head when reading? ☐Yes ☐No When _____

Holding reading further away ☐Yes ☐No When _____ Bothered by light? ☐Yes ☐No When _____

Closing one eye? ☐Yes ☐ No When _____ Inability to see distance objects? ☐Yes ☐No When _____

Covering one eye? ☐Yes ☐No When _____ Bumping into objects? ☐Yes ☐No When _____

Eyes frequently reddened? ☐Yes ☐No When _____ Poor general coordination? ☐Yes ☐No When _____

Frequent styes? ☐Yes ☐No When _____ History of eye surgery / patching? ☐Yes ☐No When _____

Excessive eye rubbing? ☐Yes ☐No When _____ Have you ever had vision therapy? ☐Yes ☐No When _____

Itchy / Watery / Irritated Eyes ☐Yes ☐No When _____ Have you ever injured your eyes? ☐Yes ☐No When _____

PLEASE COMPLETE THE OTHER SIDE

HEALTH HISTORY

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

Systemic Disease/Condition	Yes	No	Relationship
Arthritis	☐	☐	_____
Diabetes	☐	☐	_____
Rheumatoid Arthritis	☐	☐	_____
Fever	☐	☐	_____
Weight loss/gain	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Drug sensitive	☐	☐	_____
Elevated cholesterol	☐	☐	_____
Heart problem/disease	☐	☐	_____
High blood pressure	☐	☐	_____
Thyroid	☐	☐	_____
Migraine or Headaches	☐	☐	_____
Skin (acne, cancer)	☐	☐	_____
Gastrointestinal	☐	☐	_____
Urogenital (kidney, bladder)	☐	☐	_____
Neurological (MS, seizures)	☐	☐	_____
Psychiatric (depression, etc)	☐	☐	_____
Allergies	☐	☐	_____
Respiratory (asthma, bronchitis, emphysema)	☐	☐	_____
Kidney Disease	☐	☐	_____
Lupus	☐	☐	_____
Other _____	☐	☐	_____

Ocular Disease/Condition	Yes	No	Relationship
Lazy eye	☐	☐	_____
Turned eye	☐	☐	_____
Color "blind"	☐	☐	_____
Light sensitive	☐	☐	_____
Eyestrain	☐	☐	_____
Dry eyes	☐	☐	_____
Floaters/spots	☐	☐	_____
Flashing lights	☐	☐	_____
Retinal detachment or retinal disease	☐	☐	_____
Blindness	☐	☐	_____
Macular Degeneration	☐	☐	_____
Cataracts	☐	☐	_____
Crossed Eyes	☐	☐	_____
Glaucoma	☐	☐	_____
Head trauma	☐	☐	_____
Eye surgery _____	☐	☐	_____

Date of your last physical: _____

How is your general health? (circle one) Excellent Good Fair Poor

Are you currently under a physician's care? Yes No Dr.'s name _____

List any major illness:	Age of Onset	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

As you complete this history questionnaire you will recognize the thoroughness with which your problem will be considered. We appreciate you taking them time to fill out this form completely and accurately. We look forward to meeting you and helping you meet your visual needs.

Signature: _____ **Date**: _____