Southeastern Indiana Vision Development Center

Eric D. Weigel, OD, FCOVD
211 East Main Street
Greensburg, IN 47240

Your Full Name: _____ Date of Birth _____

Address: _____ Age now _____

City: _____ State: _____ Zip: _____ Referred by_____

Home Phone: _____ Business Phone: _____ Cell Phone _____

Occupation: _____ Do you currently attend school? ☐Yes ☐No Where? _____ Grade?_____

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? _____

Does your job include using a computer? ☐Yes ☐No Hrs. per day ____

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

_____

How long has your difficulty been noticed? _____

Previous visual examinations: Reason for exam	Date of Exam	Doctor's name	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

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 at Near ☐Yes ☐No When? _____		Eye Surgery? ☐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 _____		Have you had any eye surgeries? ☐Yes ☐No When _____	
Excessive eye rubbing? ☐Yes ☐No When _____		Have you ever had vision therapy? ☐Yes ☐No When _____	
Get lost in book? unaware peripherally ☐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	☐	☐	_____
Stroke	☐	☐	_____
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)	☐	☐	_____
Other _____	☐	☐	_____
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 _____	☐	☐	_____

Please list any other pertinent health information here:

_____

_____

_____

_____

_____

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 _____

What reason? _____

Are you taking any medications regularly? Yes No If yes, what medications: 1 _____

2 _____ 3 _____ 4 _____ 5 _____

List any major illness: Age Mild Severe

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

As you complete this history questionnaire you will recognize the thoroughness with which your problem will be considered. The office examination will take up enough time to permit a very complete optometric investigation of any problem. I am looking forward to meeting you and helping you meet your visual needs. In order for us to keep costs down, payment is expected in full at the time of service; We do not accept assignment from insurance companies. All payments are between the patient and our office.

I authorize the release of medical and/or other information pertinent to my care to the Southeastern Indiana Vision Development Center to help facilitate proper care.

Signature: _____ **Date**: _____