



Advanced Eyecare Specialists  
www.aeswpb.com

## Adult Sensorimotor History

**Please bring this form to your appointment. If you have ever had any other testing which Dr. Manes should be aware of, please provide a copy.**

### General Information

Patient's full name \_\_\_\_\_  
If married, name of spouse \_\_\_\_\_

### Visual Health History

Reason for today's visit \_\_\_\_\_  
\_\_\_\_\_  
Date of last vision examination \_\_\_\_\_  
Results \_\_\_\_\_  
Previously Diagnosed Visual Conditions \_\_\_\_\_  
Previous Treatments for Visual Conditions \_\_\_\_\_  
\_\_\_\_\_

Are you currently taking any eye drops? \_\_\_\_\_  
Do you wear glasses?  
 Yes  No  
 Constantly  Occasionally  
 Near  Far

If you have more than one pair of glasses, please describe how/ when you use them. \_\_\_\_\_  
\_\_\_\_\_

Do you wear contact lenses?  
 Yes  No  
 Full time wear  Occasional wear

**Please describe your main visually demanding activities and any difficulties you encounter in doing them.**

**Visual demands** (reading, computer, etc.)  
At work \_\_\_\_\_  
\_\_\_\_\_

At play (sports hobbies) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any history of the following? (please check)  
You Family

- |                      |                          |                          |
|----------------------|--------------------------|--------------------------|
| High blood pressure: | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye turn/Strabismus: | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes:            | <input type="checkbox"/> | <input type="checkbox"/> |
| Premature birth:     | <input type="checkbox"/> | <input type="checkbox"/> |
| Retinal disease:     | <input type="checkbox"/> | <input type="checkbox"/> |
| Headaches/migraines: | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus problems:      | <input type="checkbox"/> | <input type="checkbox"/> |
| Lazy Eye/Amblyopia:  | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies:           | <input type="checkbox"/> | <input type="checkbox"/> |
| Color deficiency:    | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma:            | <input type="checkbox"/> | <input type="checkbox"/> |

### Medical History

Most recent medical examination:  
Doctor's name \_\_\_\_\_  
Date \_\_\_\_\_  
Results \_\_\_\_\_

Medication currently taking \_\_\_\_\_  
For what condition \_\_\_\_\_

**Have you been diagnosed as having :**

- |  |   |
|--|---|
| <input type="checkbox"/> Learning disabilities | <input type="checkbox"/> Developmental delays |
| <input type="checkbox"/> ADD or ADHD           | <input type="checkbox"/> Cerebral Palsy       |
| <input type="checkbox"/> Seizure Disorders     | <input type="checkbox"/> Autism               |
| <input type="checkbox"/> Other problems        | _____   |

List illnesses, bad falls, head injuries, high fever, ear infections, etc. (include complications and ages)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you generally healthy? \_\_\_\_\_

Are there any chronic problems like asthma, hay fever, allergies? \_\_\_\_\_

If so, please list \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Has a neurological evaluation been performed?  Yes  No

By whom? \_\_\_\_\_

Results \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Has a psychological evaluation been performed?  Yes  No

By whom? \_\_\_\_\_

Results \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Have you ever received:**

Occupational therapy services?  Yes  No

By whom and when? \_\_\_\_\_

Results \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Physical therapy services?  Yes  No

By whom? \_\_\_\_\_

Results \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Speech therapy services?  Yes  No

By whom? \_\_\_\_\_

Results \_\_\_\_\_

Other therapy? \_\_\_\_\_

**Present Situation**

Is there any concern that some visual dysfunction may be present? \_\_\_\_\_

If so what? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Is your visual dysfunction interfering with your ability to perform your daily functions either at home or work? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Do you experience any of the following:**

Headaches  Yes  No

When? \_\_\_\_\_

Blurred vision  Yes  No

When? \_\_\_\_\_

Double vision  Yes  No

When? \_\_\_\_\_

Eyes "hurt or tired"  Yes  No

When? \_\_\_\_\_

Difficulty reading  Yes  No

Describe \_\_\_\_\_

Difficulty driving  Yes  No

When? \_\_\_\_\_

Difficulty coordinating the eyes as a team  Yes  No

When? \_\_\_\_\_

Poor depth perception/ spatial judgments  Yes  No

Describe \_\_\_\_\_

Other visual perception problems  Yes  No

Describe \_\_\_\_\_

Eyes frequently reddened  Yes  No

If so, when? \_\_\_\_\_

Frequent eye rubbing  Yes  No

If so, when? \_\_\_\_\_

Frequent blinking  Yes  No

If so, when? \_\_\_\_\_

Closing or covering one eye  Yes  No

If so, when? \_\_\_\_\_

Head close to paper when reading  Yes  No

or writing:

Tilting head when reading  Yes  No

Tilting head when writing  Yes  No

Reversing letters or words  Yes  No

Skip, reread or omit words  Yes  No

Vocalizing when reading silently  Yes  No

Reading slowly  Yes  No

Using a finger as a marker  Yes  No

Poor reading comprehension  Yes  No

Poor writing or printing  Yes  No

Avoid near tasks  Yes  No

- Short attention span  Yes  No
- Poor motor coordination  Yes  No
- Difficulty catching/hitting a ball  Yes  No

List any other concerns that you have concerning your vision: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

***I authorize the release of any medical information to process my insurance claim or the referral to another doctor, school or clinic.***

Signed \_\_\_\_\_

Date \_\_\_\_\_

**Educational/ Occupational History**

Level of education received \_\_\_\_\_

**Please check all that apply to you.**

- Slow learner  Yes  No
- Motion sensitive  Yes  No
- Poor diet/ nutrition  Yes  No
- Crave sweets  Yes  No
- Difficult childhood  Yes  No
- History of substance abuse  Yes  No
- History of trouble with the law  Yes  No
- Musical ability  Yes  No
- Good rhythm  Yes  No
- Light sensitive  Yes  No
- Touch sensitive  Yes  No
- Enjoy sports  Yes  No
- Read for enjoyment  Yes  No
- Hands on learner  Yes  No

**Goals:**

Satisfied with current occupational situation  Yes  No  
 If no, please give a reason why \_\_\_\_\_  
 \_\_\_\_\_

Satisfied with level of education received  Yes  No  
 If no, please give a reason why \_\_\_\_\_  
 \_\_\_\_\_