optometry@cooroy
guidance to enhance, transform & preserve your vision

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NEW NEURO-OPTOMETRY PATIENTS QUESTIONNAIRE

By filling out this form you will be giving us valuable information to assist us with your examination.

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other ……..

First name *(as on Medicare card)* …….. …….. Known as ……..

Last name *(as on Medicare card)* …….. Date of birth ……/……/……

Medicare Number …… Reference Number…….. Expiry ……

Residential Address …… Postal Address (if different) ……..

…… ……

…… Postcode …….. …… Postcode ……..

☐ Landline Phone …… ☐ Mobile …… ☐ Work ……

☐ Email ……..…… (*Please tick your preferred first method of contact)*

BILLING

Has billing for your Optometric care been pre-approved by any of the following? ☐ Yes ☐ No ☐ Not sure

☐ WorkCover ☐ CTP Insurance ☐ Other (please name) ……..

If applicable, your case number? …. …… Case Manager ……..……..

Contact details of Case Manager ……..……..……

RELEVANT TO YOUR VISUAL NEEDS

Occupation ……..……..……

What hobbies or sports do you participate in? ……..……

……

Do you use any of the following?

☐ Desktop computer
☐ Laptop computer
☐ Tablet or iPad
☐ Mobile phone
☐ Gaming Device
☐ Kindle or E-reader

VISUAL HISTORY

Were you referred for an Optometric assessment due to your medical condition (e.g. ABI, concussion or vertigo)?

☐ Yes ☐ No

If yes, who referred you (including clinic name)? ……..……..……..……..……..……..……

……

When was your last visual examination (approximately) ? ……..……..

By whom and where? ……..……..……

Do you use any of the following?

☐ Prescribed glasses
☐ Prescription sunglasses
☐ Non-prescription sunglasses
☐ Contact lenses
☐ Over-the-counter magnifying glasses
☐ Non-prescription blue-light blocking glasses
☐ Non-prescription neurological tinted glasses
☐ Safety glasses

List any eye / vision treatment other than glasses or contact lenses? *(including eye surgery & eye exercises)*

……

Do you use any eye drops? ☐ Yes ☐ No If yes, please list those you use ……..……..……..

……

Continued on the next page

CURRENT VISUAL SYMPTOMS

Please fill out the Brain Injury Vision Symptom Survey (BIVSS) on the next page.

Are you also experiencing any of the following?

- ☐ Sudden loss of vision
- ☐ Regular headaches (not related to when using your eyes)
- ☐ Floating spots in your vision
- ☐ Flashing lights in your vision
- ☐ Other symptoms not listed ……
- ☐ Eye strain
- ☐ Burning or itchy eyes
- ☐ Red eyes
- ☐ Distorted (wavy or wobbly) vision

…….....

…….....

FAMILY HISTORY

Do you have a family history of any of the following?

- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Cataract
- ☐ Diabetes
- ☐ Retinal detachment
- ☐ Retinitis Pigmentosa
- ☐ Strabismus (turned eye)
- ☐ Amblyopia (lazy eye)

MEDICAL HISTORY

Name of your G.P ……..

Medical Clinic ..……..……..……..……..……..……..……..……..

Please list any other medical or allied health professionals involved in your care?

…….....

…….....

…….....

…….....

Please list any medications you are taking *(including natural supplements)*

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Do you have or have experienced any of the following?

- ☐ Diabetes
- ☐ Heart problems
- ☐ Allergies / asthma
- ☐ Arthritis
- ☐ Cancer, type …….
- ☐ Autoimmune disease, list …….
  ……
- ☐ Other conditions you feel are relevant ……
- ☐ High blood pressure
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Multiple sclerosis
- ☐ Plaquenil use
- ☐ Methotrexate use

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PRIVACY STATEMENT

At optometry@cooroy your privacy is our priority. Your personal information that we collect and hold about you is handled with the utmost confidentiality and security and in accordance with the Privacy Act. We may use your personal contact information to send you regarding eye health, eye care and eyewear with your consent. For more information on how we manage your privacy please contact our practice.

Do you consent to us sending you occasional communications including appointment reminders, eye health information & promotions relevant to you via email, SMS or post? ☐ Yes ☐ No ☐ Not sure

Your Signature.....…….. **Date**.....……

BIVSS CHECKLIST (Brain Injury Vision Symptom Survey)

Patient Name: _____

My brain injury was: ____ years ago today's date: _____

☐ I have had a medical diagnosis of brain injury (check box if true) Cause of injury: _____

☐ I sustained a brain injury without medical diagnosis (check box if true) _____

☐ I have NOT ever sustained a brain injury (check box if true)

Please check the most appropriate box, or circle the item number that best matches your observations.
All information will be held in confidence. Thank you for your help!

SYMPTOM CHECKLIST ***Circle a number below:***

Please rate each behavior. **How often does each behaviour occur?** (circle a number)	Never	Seldom	Occasionally	Frequently	Always
EYESIGHT CLARITY					
Distance vision blurred and not clear -- even with lenses	0	1	2	3	4
Near vision blurred and not clear -- even with lenses	0	1	2	3	4
Clarity of vision changes or fluctuates during the day	0	1	2	3	4
Poor night vision / can't see well to drive at night	0	1	2	3	4
VISUAL COMFORT					
Eye discomfort / sore eyes / eyestrain	0	1	2	3	4
Headaches or dizziness after using eyes	0	1	2	3	4
Eye fatigue / very tired after using eyes all day	0	1	2	3	4
Feel "pulling" around the eyes	0	1	2	3	4
DOUBLING					
Double vision -- especially when tired	0	1	2	3	4
Have to close or cover one eye to see clearly	0	1	2	3	4
Print moves in and out of focus when reading	0	1	2	3	4
LIGHT SENSITIVITY					
Normal indoor lighting is uncomfortable – too much glare	0	1	2	3	4
Outdoor light too bright – have to use sunglasses	0	1	2	3	4
Indoors fluorescent lighting is bothersome or annoying	0	1	2	3	4
DRY EYES					
Eyes feel "dry" and sting	0	1	2	3	4
"Stare" into space without blinking	0	1	2	3	4
Have to rub the eyes a lot	0	1	2	3	4
DEPTH PERCEPTION					
Clumsiness / misjudge where objects really are	0	1	2	3	4
Lack of confidence walking / missing steps / stumbling	0	1	2	3	4
Poor handwriting (spacing, size, legibility)	0	1	2	3	4
PERIPHERAL VISION					
Side vision distorted / objects move or change position	0	1	2	3	4
What looks straight ahead--isn't always straight ahead	0	1	2	3	4
Avoid crowds / can't tolerate "visually-busy" places	0	1	2	3	4
READING					
Short attention span / easily distracted when reading	0	1	2	3	4
Difficulty / slowness with reading and writing	0	1	2	3	4
Poor reading comprehension / can't remember what was read	0	1	2	3	4
Confusion of words / skip words during reading	0	1	2	3	4
Lose place / have to use finger not to lose place when reading	0	1	2	3	4