VIRGINIA NEURO-OPTOMETRY

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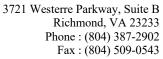
Neuro-Optometric History Form

Brain Injury/Neuro History: Please briefly describe your injury/accident/diagnosis (date, time, loss of consciousness, symptoms at time of injury, etc) and/or reason for coming to our practice:

Did you have neuroimaging performed, and if so when and what type/results (e.g., CT or MRI of brain):
What are your main visual concerns that are bringing you in?
Of all of the things that you have had difficulty doing, what is the top 1-3 things that are the MOST important for you to return to/regain? 1)
2)

CISS: In regards to symptoms when reading or doing close/computer work:

Case in regular to symptoms when returning or doing	Never	Rarely	Sometimes	Frequently	Always
□ Eyes feel tired	0	1	2	□3	4
☐ Eyes feel uncomfortable	□ 0	1	□ 2	□3	4
□ Eyes feel sore	□ 0	1	□ 2	□ 3	□ 4
□ Eyes hurt	□ 0	1	□ 2	□ 3	□ 4
☐ Feel a "pulling" feeling around the eyes	0	1	2	□ 3	4
☐ Get headaches	0	1	2	□ 3	4
☐ Feel sleepy/tired	0	1	2	□ 3	□ 4
☐ Lose concentration	□ 0	1	□ 2	□3	4
☐ Have trouble remembering what you read	□ 0	1	□ 2	□ 3	4
☐ Have double vision	□ 0	1	□ 2	□ 3	□ 4
☐ Words move, jump, swim, or float on the page	□ 0	1	□ 2	□ 3	□ 4
□ Read slowly	0	1	2	□ 3	4
□ Words blur or come in and out of focus	□ 0	1	□2	□3	4
☐ Lose your place	□ 0	1	□ 2	□ 3	4
☐ Have to re-read the same line of words	□ 0	1	□2	□ 3	□ 4

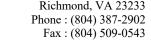




Your Vision Symptoms: Please mark (x) each symptom you have experienced in the last 4 weeks or

since your injury.	
Visual Clarity	☐ Blurry vision at distance with head stable
	☐ Blurry vision at distance with head moving
	□ Blurry vision at near
	☐ Blurry vision fluctuates throughout the day
	□ Reduced vision at night
Double Vision	□ Double vision is horizontal – two images side by side
	□ Double vision is vertical – two images up and down
	□ Double vision is at distance
	□ Double vision is at near
Visual Tasks	□ Headaches
Provoke	□ Dizziness
Physical	□ Nausea
Symptoms of	☐ Brain fog – confusion, disorientation
	□ Fatigue
	□ Eye pain
	□ Eye strain
Light	□ Normal indoor lighting
Sensitivity to	□ Fluorescent indoor lighting
	□ Outdoor sunlight
	□ Electronics/screens
	☐ Flashing/strobing/flickering lights
Dry Eye	□ Vision/light sensitivity worse in the morning
Symptoms	□ Vision/light sensitivity worse in the afternoon
	□ Eyes sting/burn/feel dry
	□ Eyes are red
	□ Eyes water
Depth	☐ Clumsiness/misjudge where objects really are in space
Perception	☐ Lack of confidence walking, missing steps, stumbling
	□ Poor Handwriting (spacing, size, legibility)
Peripheral	☐ Side vision is distorted/objects move or change position
vision	☐ Missing piece/part of peripheral vision
	□ Difficulty with visual motion
	□ Carsickness
	□ Flashes of light
	□ Floaters
Visual	☐ Anxiety in visually crowded areas (restaurants, grocery stores)
Processing	☐ Difficulty with visual search tasks (ex: can't find the milk in the fridge)
	□ Difficulty concentrating on a task
	□ Poor ability to organize work
	□ Confusion following a series of verbal instructions
	□ Confusion following a series of written instructions
	□ Confusion with directional orientation/maps/planning in space
	□ Difficulty with memory

Other symptoms not listed above:





Vision Quality of Life with Time Survey (VisQuaL-T)

Please fill out if any of the following activities below give you symptoms, and if so, how long it takes before they begin. Symptoms include headache, dizziness, eye strain, double vision, floating words, blurry vision, inability to pay attention, easily distracted, or sleepy/drowsy. If you do not perform a specific activity and it is not applicable to you, select N/A. If you never experience any of the symptom listed above for the specific activity, select 60+ min. Note: If you select more than four N/A's, fill out one Optional Additional Activity for each N/A's above four. For example, if you selected 6 N/A's, fill out two of the Optional Additional Activities.

In the Ontional Activities fill out an activity you perform regularly that is more applicable to you

In the Optional Activities, fill out an activity you perform regularly that is more applicable to you.								
Activities Important to You	0 – 15 min	15 – 30 min	30 – 45 min	60+ min	N/A			
Read for pleasure?	□ 0	□ 1	□2	□ 3	4			
Study for a test / examination?	□ 0	1	2	3	4			
Complete homework?	□ 0	1	2	3	4			
Complete work in an office setting? (i.e. reading / writing /	□ 0	1	2	□ 3	4			
typing reports)								
Be in crowded locations? (i.e. malls, train station, airports,	□ 0	1	2	□ 3	4			
meetings, busy walkways, etc.)								
Tolerate habitual lighting in a classroom or workplace?	□ 0	1	□2	□ 3	4			
Use a smartphone / tablet?	□ 0	□ 1	□2	□ 3	4			
Play a computer / console video game?	□ 0	1	2	□ 3	4			
Use a computer or laptop for general purposes? (i.e. email,	□ 0	1	2	3	4			
Facebook, etc.)								
Watch a show / movie on a screen larger than 9"? (iPad Pro or	□ 0	1	2	3	4			
larger)								
Additional Activity 1:		1	2	3	4			
Additional Activity 2:	□ 0	1	2	3	4			