

New Patient Demographic Information

Patient Legal Name (Please print) Preferred/Nickname Date of Birth (mm/dd/yyyy)

Birth Sex Gender Identity Preferred Pronouns

Email Address: _____
Home Phone: _____ Cell Phone _____ Work Phone _____
Address _____
City _____ State _____ Zip Code _____

Preferred contact method (check all that apply): Phone Text Email
Is voicemail okay? Yes No

Emergency Contact:

Name: _____ Relation: _____ Phone: _____

Parent Names: Please list all parent/guardian first/last names and relation to patient with preferred phone/email if different than contact information (John Smith – Father)

Spouse or Partner: Please list your spouse or partner's name if you would like to authorize us to be able to speak with them about your case or call to schedule or move appointments, or if they will be with you at visits etc.

Family or Friends Disclosure: Please list anyone whom you authorize for access to PHI. We will not disclose any PHI without your permission, but can confirm appointment times, cancel appointments, or give any information to the people listed above who you may need to assist you with your care. Please list the name, relationship, and what permissions (ie: appointment times only, billing, etc).

Text Message Opt In:

By checking this box you agree to receive SMS messages from Virginia Neuro-Optometry related to (appointment reminders, physician timelines on appointment days or if our phone line is busy, etc). You may reply STOP to opt out at any time. Reply HELP for assistance. Messages and data rates may apply. Message frequency will vary. Learn more about our privacy policy page and Terms and Conditions on our website: www.VirginiaNeuroOptometry.com

I opt out of text messages

PATIENT ACKNOWLEDGMENT & CONSENT

By signing below, I acknowledge and agree to the following and have been provided these documents

- I have received the Notice of Privacy Practices.
- I consent to evaluation and treatment by Virginia Neuro-Optometry.
- I understand this practice is fee-for-service and out-of-network with commercial insurance and Medicare. I have received a good faith estimate of services and understand payment is due at time of visit via cash, check or credit card and I am financially responsible for all charges
- I consent to electronic communication, portal use, and telemedicine when applicable.
- I agree to clinic safety and etiquette policies.

Patient/Guardian Signature: _____ **Date:** _____

Preferred Pharmacy Name: _____

Address: _____

Phone Number: _____

Date of Injury: _____

Is this under worker's compensation (Yes/No)? _____

If Yes, who is your case manager/adjuster (name, phone number, email)?

- Referring Provider Name: _____ Office/Location: _____
- Attorney Name (if applicable) _____

Healthcare Team:

Please list the name & office name/location of your Healthcare providers:

- PCP/Pediatrician: _____
- Optometrist: _____
- Ophthalmologist: _____
- Neurologist: _____
- Other: _____

Allergies:

Medication/Food/Environment	Allergic Reaction	Severity

Current Medications, Including Supplements:

Name of Medication/ Vitamin/Supplement/Herb	Dose (how much do you take)	Frequency (how many times do you take it per day)	Is it helpful/reason for taking?

Have you recently started or stopped taking a new medication (If Yes, which one)?

Patient History/Medical Information

What were you referred for?

- Neuro-optometric examination
 - Post-Concussion/Traumatic Brain Injury Neuro-Optometric Evaluation
 - Double vision/Strabismus/Amblyopia examination
 - Post-stroke Functional Visual Field Loss Examination
 - Developmental Pediatric Evaluation
 - Neuro-Optometric Evaluation
 - Visual processing examination
 - Occupational Therapy Evaluation
 - Adult Cognitive Occupational Therapy Evaluation
 - Other: _____

Who Referred you to Virginia Neuro-Optometry clinic? _____

- Self -Referred

Reason for Visit: Please describe your primary reason for coming to our practice, including any relevant accident details (date/time/type of injury, etc):

Have you had neuroimaging performed, and if so when and what type/results (e.g., CT or MRI of brain): _____

Do you have a history of (other) previous concussions or brain injuries? Yes No
(If yes, please give brief history):

What are your main concerns/symptoms that are bringing you in?

Please list specific daily tasks you struggle with (le laundry, shopping, spelling):

Of all of the things that you have had difficulty doing, what are the top 1-3 things that are the MOST important for you to return to/regain

- 1) _____
- 2) _____
- 3) _____

What are your main goals for our testing/evaluation today?

Educational History: *Please answer if you are CURRENTLY in SCHOOL*

Current Grade Level: _____

School Name: _____ Type (Public/Private, etc): _____

School Location: _____

Resources: 504 plan IEP (Individualized Education Program) Other _____

Subjects: Please list any specific academic tasks/skills/subjects you struggle with:

Work/Occupational History: *Please answer if you are of working age*

Occupation: _____ Employer: _____

Are you working currently? Yes No

How many hours per day/days a week are you CURRENTLY working? _____

- How many hours per day/days a week were you working pre-injury?

Please list any tasks at work that you are struggling with because of your symptoms

Screen Use History:

Hours/day currently using cellphone: _____. Hours/day currently using tablet/computer: _____.

Pre-Injury Screen use abilities (hours/day): _____

Please list any modifications you are currently using (night mode, glare screen, etc):

Describe your desk set up: (select all that apply)

Laptop Desktop Ipad/Tablet

Multiple Screens (describe): _____

Symptoms: Please mark (x) each symptom you have

VISUAL CLARITY

- Blurry Vision - Right Eye Left Eye Both Eyes
- Blurry vision fluctuates throughout the day
- Blurry vision at distance with head stable
- Blurry vision that is constant
- Blurry vision at distance with head moving
- Vision is worse at night
- Blurry vision at near
- Vision is worse in the morni

GLASSES & CONTACTS

Please describe if you wear glasses/contacts, what for, and if they are working for you:

PERIPHERAL VISION/VISUAL FIELD LOSS

Please describe your peripheral vision/Visual Field loss:

VISUAL DISTURBANCES

- Vision feels dimmer and/or dark
- Vision feels “slow”
- Has visual static/snow in my vision
- Sees visual after images of things after looks at them
- Visual hallucinations (sees things that are not really there): Please describe:

Flashes of light --- Please describe what they look like, which eye and how often they occur:

Floaters --- Please describe what they look like, which eye and how often they occur:

VISUAL MOTION SENSITIVITY

What visual motion tasks (scrolling, driving, etc) are most triggering?

Abnormal peripheral visual motion – feel like something is there when it is not

DEPTH PERCEPTION

- | | |
|---|---|
| <input type="checkbox"/> Clumsiness | <input type="checkbox"/> Lack of confidence walking |
| <input type="checkbox"/> Bumping into things | <input type="checkbox"/> Imbalance |
| <input type="checkbox"/> Difficulty judging where things are in space | <input type="checkbox"/> Missing steps/stairs |
| <input type="checkbox"/> Tripping over things | <input type="checkbox"/> Stumbling |
| <input type="checkbox"/> Other: _____ | |

DOUBLE VISION

- Double vision is horizontal – two images side by side
- Double vision is vertical – two images up and down
- Double vision is diagonal
- Double vision is worse in one gaze (ie left vs right, up vs down, etc): _____
- Double vision is at distance
- Double vision is at near

LIGHT SENSITIVITY

What types of lighting are you sensitive to:

- | | |
|---|--|
| <input type="checkbox"/> Normal indoor overhead/incandescent lighting | <input type="checkbox"/> Electronics/screens |
| <input type="checkbox"/> Fluorescent indoor lighting | <input type="checkbox"/> Overcast outdoor lighting |
| <input type="checkbox"/> LED lighting | <input type="checkbox"/> Flashing/strobing/flickering lights |
| <input type="checkbox"/> Outdoor sunlight | <input type="checkbox"/> Glare at night |

Have you always been light sensitive? No Yes and it is the same Yes, but it is worse

VISUAL TASKS PROVOKE PHYSICAL SYMPTOMS OF

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Dizziness/lightheadedness | <input type="checkbox"/> Eye pain |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Eye strain |
| <input type="checkbox"/> Brain fog – confusion, disorientation | |

HEADACHES

Describe your headache (type of pain, location, duration, time of onset):

What tasks provoke headaches (triggers)?

What makes your headaches feel better?

What headache medications do you currently take?

Do you think they help?

What have you tried that did not help?

Do you have a headache when looking at a phone or computer screen? Yes. No

Do you have a headache when you wake up? Yes. No

Do you have neck pain/stiffness? Yes. No

--- please describe: _____

DIZZINESS/NAUSEA

What tasks provoke dizziness? _____

Do you have spinning (vertigo?) Yes. No

--- What tasks provoke vertigo? _____

Do you have lightheadedness Yes. No

--- What tasks provoke lightheadedness _____

Do you have Nausea Yes. No

--- What tasks provoke nausea? _____

Do you have Carsickness? Yes. No

--- Have you always been prone to getting carsick?

No Yes and it is the same Yes, but it is worse

--- How often & how quickly do you get motion sick? _____

OCULAR DISCOMFORT

Eye Strain. ---- Right Eye Left Eye. Both Eyes

Eye Pain . ---- Right Eye Left Eye. Both Eyes

Eyes burn

Eyes itch

Eyes feel dry

Eyes sting

Eyes are red

Eyes water/tear

- Do you currently use eyedrops? No Yes

---- If yes, which ones/how many times a day?: _____

MOOD CONCERNS

Feel sad

Difficulty turning off thoughts

Constantly thinking about symptoms

Nervous/Anxious

Feels more stressed than usual

VISUAL-COGNITIVE PROCESSING CONCERNS

Difficulty with memory

--- What types of things are hard to remember (Ex: conversations, names, phone numbers, appointments)? _____

Brain fog/slow thinking – provoked by _____

Confusion/disorientation – provoked by _____

Anxiety or feeling overwhelmed in visually crowded areas (restaurants, grocery stores)

Difficulty with visual search tasks (ex: can't find the milk in the fridge)

Difficulty multitasking

Difficulty switching attention back and forth between 2 or more different tasks

Difficulty initiating tasks

Confusion with directional orientation/maps/planning in space

Noisy or competing background noises make my cognitive symptoms worse

---Please list any other triggers that worsen your cognitive symptoms:

Confusion following a series of verbal instructions

Confusion following a series of written instructions

Difficulty staying organized

Other visual and/or cognitive symptoms:

Please describe any strategies that you currently use to compensate for your visual-cognitive symptoms:

Convergence Insufficiency Symptom Survey (CISS)

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

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

Dizziness History: (ONLY fill out if you have dizziness, otherwise skip to next section)

1. Do you have spinning or whirling sensation of the surroundings or yourself? _____
2. Do you feel dizzy mostly when your head is moved? _____
3. Does the dizziness last <3 min? _____
4. Which positional change makes you feel *more dizzy*?
 Lying down/getting out of bed. OR Turning your head or body while lying down
5. Which makes you more dizzy?
 Turning your head to the right OR Turning your head to the left
OR No difference
6. How long does the dizziness induced by head turning last? <1 min OR ≥1 min

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.

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

Previous and Current Rehabilitation Therapy:

- Physical Therapy _____
- Occupational Therapy _____
- Speech and Language Therapy _____
- Neuro-psychology _____
- Psychological Consult/Counseling _____
- Vision Therapy _____

Your General Symptoms: Please mark (x) each symptom you have

GENERAL

- | | | |
|---|---|---|
| <input type="checkbox"/> Unexpected Weight loss | <input type="checkbox"/> Fevers or Chills | <input type="checkbox"/> Trouble Sleeping |
| <input type="checkbox"/> Unexpected Weight Gain | <input type="checkbox"/> Pain | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> General Fatigue | |
| <input type="checkbox"/> Decreased Appetite | <input type="checkbox"/> Malaise/lethargy | |
| <input type="checkbox"/> Other: _____ | | |

HEAD, EAR, NOSE & THROAT

- | | | |
|---|---|---|
| <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Postnasal drip | <input type="checkbox"/> Loss of smell |
| <input type="checkbox"/> Jaw pain while chewing | <input type="checkbox"/> Nasal discharge | <input type="checkbox"/> Loss of taste |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Tinnitus | <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Voice Hoarseness |
| <input type="checkbox"/> Nasal stuffiness | <input type="checkbox"/> Vertigo | |
| <input type="checkbox"/> Other: _____ | | |

CARDIOVASCULAR

- | | | |
|--|---|---|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Heart rate variability | <input type="checkbox"/> Leg/ankle Swelling |
| <input type="checkbox"/> Dizzy/lightheaded when standing | <input type="checkbox"/> Discomfort when breathing while lying down | <input type="checkbox"/> Fainting/passing out |
| <input type="checkbox"/> Palpitations | | |
| <input type="checkbox"/> Other: _____ | | |

RESPIRATORY

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Trouble breathing | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Snoring | |
| <input type="checkbox"/> Other: _____ | | |

GASTROINTESTINAL

- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Trouble swallowing | <input type="checkbox"/> Constipation | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Diarrhea | |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Heartburn | |
| <input type="checkbox"/> Other: _____ | | |

GENITOURINARY

- | | | |
|---|---|--|
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Painful urination |
| <input type="checkbox"/> Other: _____ | | |

MUSCULOSKELETAL

- | | | |
|--|---|---|
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Restriction in neck mobility |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Neck stiffness | |
| <input type="checkbox"/> Other: _____ | | |

SKIN & HAIR

- | | | |
|---|--|--|
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Rash | <input type="checkbox"/> Decreased body hair |
| <input type="checkbox"/> Dry or brittle hair or nails | <input type="checkbox"/> Increased body hair | <input type="checkbox"/> Loss of scalp hair |
| <input type="checkbox"/> Other: _____ | | |

NEUROLOGIC

- | | | |
|--|---|--|
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Weakness | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Tremors or involuntary movements | <input type="checkbox"/> Lightheadedness |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Tingling | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Numbness or loss of sensation | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Migraine |
| | | <input type="checkbox"/> Headache |

Loss of Consciousness

Other: _____

COGNITIVE

Confusion

Difficulty with memory

Difficulty finding your words

Disorientation

Difficulty with speech – stuttering

Cognitive fatigue

Brain fog

Other: _____

PSYCHIATRIC

Nervous/Anxiety

Irritability

Depression

PTSD

Other: _____

ENDOCRINE

Cold sensitivity

Irregular menstrual period

Decreased libido

Heat sensitivity

Other: _____

Personal Ocular History:

Date of last eye exam: _____

Date of last dilation: _____

Optometrist: _____ Ophthalmologist: _____

Please list any ongoing eye conditions you have currently or have had in the past.

Wears Glasses

Direct trauma to the eye

Wears Contacts

Chemical exposure to the eye

Strabismus (eye turn) – Right Eye

Cranial nerve Palsy

Strabismus (eye turn) – Left eye

Glaucoma

History of patching therapy for strabismus

Retinal Tear

History of strabismus surgery

Retinal Detachment

Amblyopia (lazy eye) – Right Eye

Cataracts

Amblyopia (lazy eye) – Left Eye

History of cataract surgery

History of vision therapy

Other: _____

Past Ocular Surgeries:

Personal Medical History:

Migraines

Long Covid

Post-Concussion Syndrome

High Cholesterol

Whiplash Injury

High Blood Pressure/Hypertension

Moderate/Severe TBI

Orthostatic hypotension

POTS/dysautonomia

Bradycardia

Hypermobility disorder

Insomnia/Sleep Disorder

Ehlers Danlos Syndrome

Sleep Apnea

Thyroid disorder _____

Anxiety

Stroke

Depression

- | | |
|---|---|
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> Autoimmune disease |
| <input type="checkbox"/> Asthma | _____ - |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD) | <input type="checkbox"/> Parkinson Disease |
| <input type="checkbox"/> Spine Injury/Back problems | <input type="checkbox"/> Alzheimer Disease/Dementia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Memory impairment |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Acid Reflux |
- Year first diagnosed with diabetes: _____. Last Blood Sugar Number: _____
 - Last Hemoglobin A1c: _____ Do you test your blood sugar at home? Yes. No
 Other conditions not listed above:

Past Surgical History (non-ocular):

Other Major Events (ex: car accidents, trauma, etc):

BIRTH/PREGNANCY HISTORY

Birth Weight: _____ Birth Method: _____
 Premature: Yes. No Gestation (weeks): _____
 Retinopathy of Prematurity: Yes. No
 Diagnosed Genetic Conditions: _____

Maternal use of any of the following drugs during pregnancy?

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Other medication that could cause birth defects | <input type="checkbox"/> Lead |
| <input type="checkbox"/> Accutane | <input type="checkbox"/> Illicit Drugs | <input type="checkbox"/> Mercury |
| <input type="checkbox"/> Methotrexate | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Cigarette Smoking |
| <input type="checkbox"/> Warfarin | <input type="checkbox"/> Radiation | |
| <input type="checkbox"/> Thalidomide | | |

Was there any exposure during pregnancy to the mother for any of the following conditions?

- | | | |
|--|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Vitamin A Excess | <input type="checkbox"/> Maternal Diabetes (not gestational) |
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Folic acid deficiency | <input type="checkbox"/> Hyperthermia |
| <input type="checkbox"/> Cytomegalovirus | <input type="checkbox"/> Pre-eclampsia | <input type="checkbox"/> Other infections |
| <input type="checkbox"/> Zika | <input type="checkbox"/> Eclampsia | |
| <input type="checkbox"/> Toxoplasmosis | <input type="checkbox"/> Gestational Diabetes | _____ |
| <input type="checkbox"/> HIV | | |

Anything else you think is relevant regarding the patient's pregnancy/birth history?

Childhood/Developmental History:

- None/Healthy
- History of high fevers as a child
- Seizures/Epilepsy
- Diagnosed with learning/reading disorders/dyslexia
- Diagnosed with ADHD
- Diagnosed with Autism Spectrum Disorder

Please list any other childhood conditions you think pertinent:

Social History/Health Habits:

Relationship Status: _____ Children: _____

Who else lives in your household? _____

Alcohol Use (check one): No Yes (_____ drinks per _____)

Smoking/tobacco:

Never Former (quit date _____) Current _____ per day, for _____ years)

Caffeine Use: No Yes :

- If yes: What types and how much/how often: _____

Sleep History:

Average Hours/Night: _____

- I sleep too much
- I don't sleep enough
- Wakes up frequently throughout the night

Sleep position:

- On back On left side Inconsistent/variable
- On stomach On right side

Other details about sleep:

Exercise/Activity History:

How often do you exercise currently and what types of exercises?

How often/long did you exercise prior to your injury (if applicable)?

What hobbies/activities do you enjoy doing? (reading, art, etc)

Anything special we need to know about you?



VIRGINIA NEURO-OPTOMETRY

3721 Westerre Parkway, Suite B
Richmond, VA 23233
Phone : (804) 387-2902
Fax : (804) 509-0543

Family Health History: Please provide health information about your family members, including grandparents, siblings, and children

Relation	Health Problem(s)
Father	
Mother	
Siblings	
Children	
Grandparents	
Other	

Family Ocular History: Please list any FAMILY members who have or had any EYE issues (Ex: Father - Cataract, glaucoma, strabismus, amblyopia/lazy eye).

Relation	Health Problem(s)
Father	
Mother	
Siblings	
Children	
Grandparents	
Other	