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EST 1983 McDONALD EYE CARE ASSOCIATES

Traumatic Brain Injury Service Patient Questionnaire

Name: **Exam Date:**

Date of Birth:

Parent's Names, if minor:		
Who referred you to our office?	Name:	
	Address:	
	Specialty:	
What date did your accident, injury or stroke occur?		
How did your brain injury occur?		
What part of your head was injured or affected?	Check apply that apply __ Forehead __ Back of head __ Top of head __ Face __ Right side __ Left side __ Whiplash/Neck	
Was the injury OPEN HEAD (bleeding) or CLOSED HEAD (non-bleeding)? Check one	__ Open __ Closed	
Did you lose consciousness?	__ Yes __ No	If yes, how long?
Were you in a coma?	__ Yes __ No	If yes, how long?
Are you involved in a lawsuit/ workman's compensation case as a result of your injury?	__ Yes __ No	

What were the symptoms **immediately following** the accident or injury? (Check all that apply)

__ Double Vision __ Blurred Vision __ Dizziness __ Flashes of light

__ Loss of balance __ Loss of memory __ Restricted motion __ Headache

__ Pain in or around eyes __ Vomiting __ Disorientation __ Neck pain/ Whiplash

__ Restricted field of view __ Other (Please explain):

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Visual History

Have you had a previous evaluation for this injury?		__ Yes __ No	
If yes, doctor's name		Date of last evaluation	
What are the main visual symptoms being experience now?			
Do you wear bifocals?	__ Yes __ No	Do you wear progressive lenses?	__ Yes __ No
Do your glasses work as well now as before the injury?		__ Yes __ No	
Do you use new glasses, contact lens or optical devices after the injury?		__ Yes __ No	
List devices recommended after the injury?			
Are they used?	__ Yes __ No	If yes, when?	
If no, why not?			
Were any additional tests, treatments or therapies recommended concerning your vision?		__ Yes __ No	
If yes, what?			
Did you undergo these treatments?	__ Yes __ No		
If yes, what were the results of the treatments?			
What other recommendations were made?			

Current Symptoms

Do you **currently** experience any of the following?

Headaches	__ Yes	__ No	__ Prior
Difficulty Changing Focus Far to Near	__ Yes	__ No	__ Prior
Difficulty Changing Focus Near to Far	__ Yes	__ No	__ Prior
Motion Sickness/ Car Sickness	__ Yes	__ No	__ Prior
Movement of Objects in Environment Bothersome	__ Yes	__ No	__ Prior
Tunnel Vision/ Loss of Visual Field	__ Yes	__ No	__ Prior
Holds Onto Things When Walking (People/Walls)	__ Yes	__ No	__ Prior
Dizziness	__ Yes	__ No	__ Prior
Confusion/ Disorientation	__ Yes	__ No	__ Prior
Bothered By Noises	__ Yes	__ No	__ Prior