Wolman Vision and Therapy Center
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Harrison, NY 10528
914.777.5767
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www.wolmanvisionandtherapycenter.com

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time and will enable us to perform a more comprehensive evaluation of your child and to better meet your child's specific visual needs.

If you have any questions or concerns that we may answer prior to your appointment, please do not hesitate to contact us.

You may leave a message for us 24 hours a day, 7 days a week. We request a minimum of 24 hours notice if you are unable to keep your appointment.

Please be on time for your examination, so that we will have the maximum opportunity to evaluate your child's visual status.

Thank You,

Stephanie L. Wolman, OD, FCOVD
Developmental Optometrist

ADULT VISION QUESTIONNAIRE

Please fill out this questionnaire carefully and return it to our office prior to your appointment.

GENERAL INFORMATION

How did you hear about our office? _____

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____

E-mail address: _____

Date of Birth: _____ Age: _____ Male: _____ Female: _____

Social Security Number: _____ Marital Status: Single Married Divorced Widowed

Occupation: _____ Employer: _____

Vision insurance plan name: _____ ID#: _____

Policy holder name: _____ Relationship to policy holder: _____

Policy holder date of birth: _____ Policy holder social security number:_____

MEDICAL HISTORY

Physician's name: _____ Date of most recent evaluation: _____

Medications currently using, including supplements: _____

Allergies to medication or food: _____

Past or present illnesses/conditions: Yes No

If yes, please list: _____

VISUAL HISTORY

Have you had a previous vision examination? Yes No

If yes, doctor's name: _____ Date of last exam: _____

Results and recommendations: _____

Were glasses prescribed? Yes No

If yes, for what and when do you wear them? _____

Were contact lenses prescribed? Yes No

If yes, what brand? _____Prescription: _____

Wearing schedule: _____ Cleaning Solution: _____

PRESENT SITUATION

Why do you feel the need for a visual evaluation? _____

_____

How long has this problem existed? _____

COMPUTERS

Do you use a computer for: work leisure

How many hours do you spend in front of a screen each day? _____

Do you experience any visual symptoms during or after computer use? Yes No

If so, what? _____

HOBBIES

Describe the types of activities that you participate in: _____

Do you experience any of the following?

_____ Blurred vision at distance
_____ Blurred vision at near
_____ Red or itchy eyes
_____ Burning eyes
_____ Eyes hurt
_____ Eyes feel tired
_____ Headaches
_____ Nausea associated with visual tasks
_____ Double vision at distance
_____ Double vision at near

_____ Moves head while reading
_____ Covers or closes one eye
_____ Avoids close work
_____ Tilts head to one side
_____ One eye turns in or out
_____ Need for bright light when reading
_____ Visual fatigue at the end of day
_____ Experience motion sickness

_____ Skips words or lines of text while reading
_____ Re-reads words or lines of text
_____ Reads slowly
_____ Uses finger or marker to keep place while reading
_____ Complains that words or lines of text “run together” or “jump around”
_____ Difficulty visualizing what is read
_____ Whispers to self or moves lips while reading

RELEASE OF INFORMATION AND INSURANCE FILING:

It is often beneficial for us to discuss examination results and to exchange information with other professionals involved in your care. please sign below to authorize the release of information.

I agree to permit information from, or copies of, my examination records to be forwarded to other health care providers or insurance carriers upon their written request or upon the recommendation of Dr. Stephanie L. Wolman when it is necessary for the treatment of my visual condition, or for the processing of insurance claims. This authorization shall be considered valid throughout the duration of treatment.

_____ _____

Signature Date

_____

Relationship to Patient

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers, who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been given by you, your *Notice of Privacy Practices*, containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the tight to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Date: _____