Wolman Vision and Therapy Center
550 Mamaroneck Avenue, Suite 200
Harrison, NY 10528
914.777.5767
slwolman@wolmanvisionandtherapycenter.com
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

VISUAL REHABILITAION 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:______________

INJURY/ACCIDENT

Date of injury: _____________ Type of injury/accident: ______________________________

What part of head was affected?: ____

Symptoms immediately following incident: ______________________________________

Which professionals have you seen so far:

Name: ___________________________ Specialty: ______________________________

Name: ___________________________ Specialty: ______________________________

Name: ___________________________ Specialty: ______________________________

Name: ___________________________ Specialty: ______________________________

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: __________________________

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: ____

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

______ Dizziness

______ Nausea associated with visual tasks

______ Experience motion sickness

______ Double vision: at distance/at near

______ Bothered by bright lights

______ Difficulty moving eyes

______ Pain with movement of eyes

______ Difficulty changing focus between near and far

______ Movement of objects is bothersome

______ Patterned carpets or clothes are bothersome to look at

______ Covers or closes one eye

______ Difficulty with or loss of peripheral vision

______ Trouble with balance

______ 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

______ Moves head while reading

______ Skips/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

______ Trouble with memory

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 right 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: ____