SPORTS VISION EVALUATION

PATIENT NAME _____ **DATE OF BIRTH** ____ /____ /_____

PERSON ACCOMPANYING PATIENT _____

CONTACT PHONE (_____) _____ - _____ **EMAIL** _____

PLEASE CONTACT US VIA: ○ PHONE ○ TEXT ○ EMAIL

HOW DID YOU HEAR ABOUT US? ○ CURRENT PATIENT ○ REFERRAL ○ INTERNET SEARCH ○ DRIVE BY ○ OTHER

THE REASON I AM SEEKING A SPORTS VISION EVALUATION IS:

_____

_____

ATHLETIC HISTORY

Please indicate which sport(s) you/ your child play:

○ ARCHERY	○ BASEBALL	○ BASKETBALL	○ DANCE	○ FOOTBALL
○ FRISBEE	○ GOLF	○ GYMNASTICS	○ HOCKEY	○ LACROSSE
○ RACING	○ RIDING	○ RACQUETBALL	○ RUGBY	○ SHOOTING
○ TENNIS	○ TRACK/FIELD	○ VOLLEYBALL	○ OTHER	

Primary sport: _____ Number of years played: _____

Coach Name(s): _____ Contact Info: _____

Please indicate the level of sports most recently played: ○ Professional ○ College/ Ju. College ○ High School ○ Travel/ Competitive ○ Rec. League ○ Leisure

Do you receive any additional coaching/training? ○ YES ○ NO

If *YES*, by whom? _____ How often? _____

Have you/ your child ever experienced a concussion? ○ YES ○ NO

If *YES,* how many? _____ When? _____

Please list any other sports-related injuries and date(s) of occurrence: _____

_____

VISUAL HISTORY

Has your/ your child's vision been previously evaluated? ○ YES ○ NO

If *YES*, date of last eye exam: _____

Doctor's name: _____ Phone: _____

Results/ recommendations: _____

Do you wear glasses? ○ YES ○ NO

Do you wear contact lenses? ○ YES ○ NO

Are you currently taking any eye drops? ○ YES ○ NO

Is there any concern that some visual dysfunction may be present? ○ YES ○ NO

If *YES*, please describe: _____

SYMPTOM HISTORY

Please indicate if you/ your child has any of the following symptoms:

Blurred vision	○ YES	○ NO
Headaches	○ YES	○ NO
Double vision	○ YES	○ NO
Eye fatigue/ache	○ YES	○ NO
Eye turn in or out	○ YES	○ NO
Difficulty catching/hitting a ball	○ YES	○ NO
Red eyes	○ YES	○ NO
Dry eyes or watering eyes	○ YES	○ NO
Frequent eye rubbing or blinking	○ YES	○ NO
Closing/ covering one eye	○ YES	○ NO
Poor attention span	○ YES	○ NO
Head tilt when reading/ writing	○ YES	○ NO
Slow reading	○ YES	○ NO
Skips/ rereads/ omits words when reading	○ YES	○ NO
Poor reading comprehension	○ YES	○ NO
Difficulty driving (if applicable)	○ YES	○ NO

MEDICAL HISTORY

Primary Care Physician: _____ Date of Last Evaluation: _____

Results/ recommendations: _____

Medications currently using, including vitamins and supplements:

_____

For what condition(s)? _____

_____

Have any of the following evaluations ever been performed?

Neurology	By whom/when? _____
General Psychology	By whom/when? _____
Academic Psychology	By whom/when? _____
Occupational Therapy	By whom/when? _____
Physical Therapy	By whom/when? _____
Speech Therapy	By whom/when? _____
Chiropractor	By whom/when? _____

Do you feel you / your child may need a referral for one of the above-listed evaluations? If *YES*, please explain. _____

_____

Are you/ is your child *currently* undergoing any therapies/treatments? If YES, please describe._____

_____

ACADEMIC HISTORY (IF APPLICABLE)

Current school/ grade: _____

Has a grade been repeated? ○ YES ○ NO

If *YES*, which and why? _____

Have you/ your child had any tutoring and/or remedial assistance? ○ YES ○ NO

Where/ from whom? _____

Overall schoolwork is: ○ ABOVE AVERAGE ○ AVERAGE ○ BELOW AVERAGE

Do you/ your child:

need to spend a lot of time/effort to maintain this performance? ○ YES ○ NO

feel academic achievement is up to potential? ○ YES ○ NO

feel tense/ under pressure when doing schoolwork? ○ YES ○ NO

like school? ○ YES ○ NO

like to read? ○ YES ○ NO

Briefly describe any other school difficulties or concerns:

_____

_____

_____

Thank you for carefully completing this questionnaire. The information supplied will allow us to perform a more comprehensive evaluation to better meet you/ your child's specific needs.

Sincerely,

Susan A. Carter, O.D.
2053 Thunderhead Rd
Knoxville, TN 37922
www.nseyecare.com

RELEASE OF INFORMATION

It is often beneficial to discuss examination results/recommendations and to exchange information with coaches/other professionals involved in care. Please sign below to authorize this exchange of information.

I agree to permit information from, or copies of, my/ my child's examination records to be forwarded to coaches, trainers, other health care providers, or insurance carriers upon their written request or the recommendation of Dr. Susan when it is necessary. I authorize Dr. Susan Carter and Northshore Specialty Eyecare to exchange information by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

_____ _____

Signature (Relationship to Patient) Date