Visual Victory Training Center

New Patient Registration Form

Welcome to our office!

Date:_____

Patient's name:_____ Age:_____ Date of Birth:_____

Address:_____ City:_____ State:____ Zip:_____
Home phone:_____ Cell phone:_____ Work phone:_____
Email address:_____ Please circle preferred method of communication
Patient occupation (if student, please provide the name of the school, and grade level):

_____

Parent/Guardian's Name(s):_____ Relationship:_____
Address (if different than above):_____

PAYMENT FOR PROFESSIONAL SERVICES IS EXPECTED WHEN SERVICES ARE RENDERED
Person responsible for payment (if different than above):_____
Address (if different than above):_____

WHO REFERRED YOU TO OUR OFFICE?_____
Questions, problems or concerns to be addressed:_____

_____

Medical Information (please complete)

General Health?_____
Does the patient have any problems with any of these systems?
Eyes Y N ; Ears, Nose, Mouth, Throat Y N ; Cardiovascular Y N ; Respiratory Y N
Allergic/Immune Y N; Endocrine (glands) Y N; Gastrointestinal Y N ; Musculoskeletal Y N
Integumentary (skin) Y N ; Hematologic (blood)/Lymphatic Y N ; Genitourintary Y N
Neurological Y N ; Psychiatric Y N
Please give details of any medical conditions:_____

_____
Has the patient ever had any surgeries? If yes, please explain:_____

_____
Other Health problems/Diagnoses:_____
Is the patient taking any medications? If so, please list:_____

_____
Does the patient smoke? Y N ; Does the patient use alcohol/other:_____

PRIMARY CARE PHYSICIAN:_____

Date of last physical exam:_____ PCP address/phone:_____

Family Optometrist:_____

Date of last eye examination:_____ OD address/phone:_____
With dilation? Y N ; Glasses or contacts prescribed? Y N ; Worn for: Fulltime Distance Reading

Family History:

Has anyone in your family ever been diagnosed with or treated for:
Amblyopia(lazy eye) Y N ; Strabismus (eye turns) Y N Cataract Y N ; Glaucoma Y N ;
Macular Degeneration Y N ; Retinal Detachment Y N ; High Blood Pressure Y N ;
Diabetes Y N ; Other:_____
(For Office Use Only) NOTES:_____

_____
Reviewed:_____ Dr. initials:____ Reviewed:_____ Dr. initials:_____Reviewed:_____ Dr. initials:____

Quality of Performance Survey
Please assign a value between 0 and 4 for each symptom.
0 = never of non-existent / 1 = seldom / 2 = occasionally / 3 = frequently / 4 = always

1. Blurred vision at near
2. Double vision
3. Headaches associated with near work
4. Words run together when reading
5. Burning, stinging, watery eyes
6. Falling asleep when reading
7. Vision worse at the end of the day
8. Skipping or repeating lines when reading
9. Dizziness or nausea associated with near work
10 Head tilt or closing one eye when reading
11 Difficulty copying from the chalkboard
12. Avoidance of reading and near work
13 Omitting small words when reading
14. Writing uphill or downhill
15. Misaligning digits in columns of numbers
16. Reading comprehension declining over time
17. Inconsistent/poor sports performance
18. Holding reading material too close
19. Short attention span
20. Difficulty completing assignments in reasonable time
21. Saying “I can’t” before trying
22. Avoiding sports and games
23. Difficulty with hand tools- scissors, screwdriver, calculator, keys
24. Inability to estimate distances accurately
25. Tendency to knock things over on desk or table
26. Difficulty with time management
27. Difficulty with money concepts, making change
28. Misplaces or loses papers, objects, belongings
29. Car sickness/motion sickness
30. Forgetful, poor memory

FOR SCHOOL AGED CHILDREN (OK TO HAVE SOMEONE HELP)

PATIENT NAME:_____

TEACHER'S NAME:_____

DATE:_____

WHAT IS YOUR BEST SUBJECT IN SCHOOL?_____

WHAT IS YOUR HARDEST SUBJECT IN SCHOOL?_____

HAS A GRADE BEEN REPEATED? YES NO

ARE YOU IN A SPECIAL CLASS FOR ANY SUBJECT? YES NO

HAVE YOU HAD AN EYE EXAM BEFORE? YES NO

DO YOU HAVE ANY TROUBLE SEEING: FAR AWAY? YES NO

UP CLOSE OR FOR READING? YES NO

AT NIGHT OR IN DIM LIGHT? YES NO

DO YOU GET HEADACHES A LOT? YES NO

DO YOU GET ITCHY EYES OR RUB THEM A LOT? YES NO

DO YOUR EYES GET RED? YES NO

DO YOU HAVE TROUBLE READING? YES NO

For Parent/Guardian:

This child was born: On time: Yes No Early:_____ Late:_____ Birth weight:_____

Please describe any complications to pregnancy or birth:_____

_____

Did the child crawl for at least two months? Yes No "Scooted"

Any other information you consider may be helpful:_____

_____

I give permission for my child to be examinated and treated by Dr. Amy Pruszenski and/or her assistants, under her guidance.

Signature:_____**Date:**_____

In order to assist the doctor in evaluating all of your child's visual needs, please circle the items that apply to your child:

Honors Curriculum Regular Classroom Special Education Resource Room
Speech/Language Occupational Therapy Repeated Grade____ Tutor for _____
Title 1 Reading Visual Perceptual Problems Poor Writing Skills Short Attention Span
Fast Reader Average Reader Slow Reader Does not enjoy reading Prefers to be read to
Poor reading comprehension Homeworks takes longer than it should Fatigue/Frustration/Stress
Smart in everything but schoolwork Inconsistent or poor sports performance
Poor Fine Motor Skills Poor Gross Motor Skills
Please circle this if there is anything else about your child's vision or performance that you would like to share with the doctor, privately.

Thank you for your time and effort to help us help your child.