Snowy Range Vision Center

Sports Vision Questionnaire

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Name _____Date_____
Address_____Phone_____
Sport(s) _____Position(s)_____
Coach_____ Trainer_____

HISTORY

Date of last eye exam _____
Eye Doctor's Name _____

Do you wear corrective lenses?	Yes	No	
-If yes, when used?	Near	Far	Full-time
Do you wear glasses?	Yes	No	
hard contact lenses?	Yes	No	
soft contact lenses?	Yes	No	
Do you have a spare pair?	Yes	No	
Do you wear your lenses when you play?	Yes	No	
Have you ever been involved in visual training?	Yes	No	

If yes, why: _____

Do you experience any of the following?

_____ Difficulty seeing

_____ Lack of consistent playing

_____ Not playing up to potential

_____ Easily distracted from visual target

_____ Difficulty in judging speed, distance, spin, or location of the ball

_____ Glare from the lights is bothersome

_____ Poor peripheral vision

_____ Visual fatigue

_____ Performance level varies from beginning to end of game

_____ Reduced performance as stress builds

OVER →

Do you use visualization/imagery techniques? Yes No
Please explain _____

Have you experienced any of the following?

_____ Double Vision at near at far both

_____ Blurry Vision at near at far both

_____ Eye Injury Yes No
Please explain _____
_____

_____ Eye Surgery Yes No
Please explain _____
_____

_____ Head Injury/Concussion Yes No
Please explain _____
_____

_____ Headaches Yes No
Please explain _____
_____

Your general health: Fair Good Excellent

Current Medications: Name Dosage
_____
_____
_____
_____
_____

Comments or concerns regarding your vision and/or difficulties:
_____
_____
_____
_____
_____

_____
Signature Date