Snowy Range Vision Center

Head Trauma/Stroke Questionnaire

Sue E. Lowe, OD Gary M. Poteet, OD Amy E. Aldrich, OD

www.snowyrangevision.com

405 S 30th, Laramie, WY 82070 307-742-2020 800-480-2023 Fax: 307-742-8917

HEAD TRAUMA / STROKE CASE HISTORY

Please fill out as much of this form as possible. Have your family, therapists and other physicians help if necessary. Please bring this form to your initial vision appointment.

Name _____ Guarantor _____

Address _____

Phone (H) _____ (W) _____

Occupation _____

Date of birth _____ Date of trauma _____

Last vision exam _____ Dr. _____

Referred by _____ phone _____

Reason for referral _____

Type of accident: Car accident Fall Hit by object
Toxic Anoxic Other: _____
CVA: Stroke, Aneurysm, Hemorrhage

Initial Care: Hospital _____
Coma _____
Unconscious _____

Subsequent/other professional care:

- **Family physician _____**
- **Neurologist _____**
- **Chiropractor _____**
- **Physical Therapy _____**
- **Occupational Therapy_____**
- **Speech _____**
- **Physiatrist _____**
- **Optometrist _____**
- **Ophthalmologist _____**
- **Osteopath _____**
- **Other _____**

OVER=>

Do you have any difficulties with the following:

_____ **blurred vision** near far both
_____ **head aches**
_____ **dizziness**
_____ **disorientation**
_____ **balance**
_____ **drifts to one side**
_____ **memory**
_____ **light sensitivity**

_____ **double vision** near far both
_____ **pain in eyes**
_____ **nausea**
_____ **objects move**
_____ **bumps into things**
_____ **restricted field**
_____ **poor attention/concentration**
_____ **reading (loss of place, fatigue, comprehension)**

_____ **Other** _____

Difficulties following accident:

Recreation _____
_____
_____

Hobbies _____
_____
_____

Work related _____
_____
_____

General Health: **Excellent** **Good** **Fair** **Poor**

Medications: **Name** **Dosage**

_____
_____
_____
_____

Allergies: _____
_____
_____

Family History:

Diabetes	**Yes**	**No**	**Retinal Problems**	**Yes**	**No**
Glaucoma	**Yes**	**No**	**Arthritis**	**Yes**	**No**
Cataract	**Yes**	**No**	**Crossed/Lazy eye**	**Yes**	**No**
Hypertension	**Yes**	**No**			

_____

Completed by **Date**

_____

Signature **Date**