Snowy Range Vision Center

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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: _____ Date of birth: _____

Occupation: _____ Date of trauma: _____

Last vision exam: _____ by _____

Referred by: _____

Reason for referral _____

Cause of Injury:

☐ Aneurism ☐ Blunt Trauma ☐ Car Accident
☐ Fall ☐ Hemorrhage ☐ Hypoxic Brain Injury
☐ Stroke ☐ Other: _____

Initial Care:

☐ Loss of consciousness; duration: _____
☐ Hospitalization; duration: _____
☐ Coma; duration: _____

Subsequent/other professional care:

Family physician: _____
Neurologist: _____
Chiropractor: _____
Physical Therapist: _____
Occupational Therapist: _____
Ophthalmologist: _____
Optometrist: _____
Physiatrist: _____
Osteopath: _____
Speech Therapist: _____
Other: _____

OVER →

Do you have any difficulties with the following:

☐ blurred vision ☐near ☐far	☐ double vision ☐near ☐far
☐ headaches	☐ pain in eyes
☐ dizziness	☐ nausea
☐ disorientation	☐ objects move
☐ balance	☐ bumps into things
☐ drifts to one side	☐ restricted field
☐ memory	☐ poor attention/concentration
☐ light sensitivity	☐ reading (loss of place, fatigue, poor comprehension)

☐ Other _____

Difficulties following accident:

Recreation _____

_____

_____

Hobbies _____

_____

_____

Work related _____

_____

_____

General Health:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Medications _____

_____

_____

Allergies _____

_____

_____

_____ _____

Completed by Date

_____ _____

Signature Date