Snowy Range VISION CENTER

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Sports Vision Questionnaire

Name: ______________________________ Date: ____________

Sport(s): ______________________ Position(s): ______________________

Coach: ______________________ Trainer: ______________________

History

Date of last eye exam: ____________

Name of optometrist or clinic: ______________________________

Do you currently wear glasses? ☐ No ☐ Yes: when/how often? ____________

Do you currently wear contacts? ☐ No ☐ Yes: when/how often? ____________

Do you wear corrective lenses when you play sports? ☐ No ☐ Yes: which? ____________

Have you ever been involved in visual training? ☐ No ☐ Yes: why? ____________

Do you use visualization or imagery techniques? ☐ No ☐ Yes: specify: ____________

Have you ever experienced an eye injury? ☐ No ☐ Yes: specify: ____________

Have you ever had a concussion or head injury? ☐ No ☐ Yes: specify: ____________

Do you experience any of the following?

1. Difficulty seeing ☐ No ☐ Yes: ☐at distance ☐at near
2. Lack of consistent playing ☐ No ☐ Yes
3. Not playing up to potential ☐ No ☐ Yes
4. Easily distracted from visual target ☐ No ☐ Yes
5. Difficulty in judging speed, distance, spin, or location of the target or ball ☐ No ☐ Yes
6. Glare from lights is bothersome ☐ No ☐ Yes
7. Poor peripheral vision ☐ No ☐ Yes
8. Visual fatigue ☐ No ☐ Yes
9. Performance level varies throughout game ☐ No ☐ Yes
10. Reduced performance as stress builds ☐ No ☐ Yes
11. Double vision ☐ No ☐ Yes
12. Blurry vision ☐ No ☐ Yes
13. Headaches ☐ No ☐ Yes
14. Other ☐ No ☐ Yes: specify:____________

How is your general health? ☐ Poor ☐Fair ☐Good ☐Excellent

Please list your current medications and dosages, and any supplements you are taking.

Name	Dosage	Per day

Please describe any comments or concerns regarding your vision and/or difficulties with sports:

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Signature

Date