



**DR. RICK THOMPSON  
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***Developmental, Rehabilitative & General Optometry***

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**HEAD INJURY/ABI PATIENT INFORMATION**

Full Name: \_\_\_\_\_ Date of Birth (mm/dd/yy): \_\_\_\_\_

Home Address: \_\_\_\_\_ OHIP #: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date of Loss: \_\_\_\_\_

Email Address: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**HEALTH HISTORY**

Family Doctor: \_\_\_\_\_

Any Hospitalizations: \_\_\_\_\_

List of Medications: \_\_\_\_\_

\_\_\_\_\_

Do you have any allergies?  Yes  No

If so, please list them here: \_\_\_\_\_

\_\_\_\_\_

*(list on back if needed)*

**Please check the box if you have any history of the following:**

- |   |  |
|---|--|
| <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Heart Problems      |
| <input type="checkbox"/> Cataracts            | <input type="checkbox"/> Thyroid Condition   |
| <input type="checkbox"/> Retinal Detachment   | <input type="checkbox"/> Allergies           |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Colour Blindness     |  |
| <input type="checkbox"/> Diabetes             |  |
| <input type="checkbox"/> Stroke               |  |
| <input type="checkbox"/> Asthma               |  |
| <input type="checkbox"/> Arthritis            |  |

Do any of the listed items above run in your family? If so, please list them here: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**VISION/MVA RELATED QUESTIONS**

Is this your first visual examination?  Yes  No  
If not, when was your last examination? \_\_\_\_\_

Have you had any eye injuries in the past?  Yes  No  
If so, please explain: \_\_\_\_\_

Have you had any eye surgeries?  Yes  No  
If so, please explain: \_\_\_\_\_

**Please check the box if you have experienced any of the following at the time of the MVA/ABI:**

- |   |   |
|---|---|
| <input type="checkbox"/> Eye Injury         | <input type="checkbox"/> CT scan                |
| <input type="checkbox"/> Closed head injury | <input type="checkbox"/> MRI                    |
| <input type="checkbox"/> Whip lash          | <input type="checkbox"/> Cranial Sacral Therapy |
| <input type="checkbox"/> Unconscious        | <input type="checkbox"/> Chiropractic Therapy   |
| <input type="checkbox"/> Physiotherapy      |   |

**Please check the box if you get overwhelmed or anxious in any of the following situations:**

- |  |   |
|--|---|
| <input type="checkbox"/> Big box stores          | <input type="checkbox"/> Public transit     |
| <input type="checkbox"/> In large groups/ crowds | <input type="checkbox"/> Around loud noises |
| <input type="checkbox"/> Driving                 |   |

Do you currently have a valid driver's license?  Yes  No  
Has your driver's license ever been suspended?  Yes  No

Do you work currently (part time or full time)?  Yes  No  
If not, what barriers prevent you from working? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## VISUAL SIGNS & SYMPTOMS

### PHYSICAL

Please check the box if you have experienced any of the following since the time of the MVA/ABI:

- |                                       |  |
|---------------------------------------|--|
| <input type="checkbox"/> Dry eyes     | <input type="checkbox"/> Eye drops               |
| <input type="checkbox"/> Burning eyes | <input type="checkbox"/> Eye turn                |
| <input type="checkbox"/> Watery eyes  | <input type="checkbox"/> Wandering eye           |
| <input type="checkbox"/> Itchy eyes   | <input type="checkbox"/> Eye pain                |
| <input type="checkbox"/> Rubbing eyes | <input type="checkbox"/> Flashes/spots in vision |
| <input type="checkbox"/> Squinting    |  |

Do you experience headaches?  Yes  No

If so, please explain: \_\_\_\_\_

### Reading

Please check the box if you have experienced any of the following since the time of the MVA/ABI:

- |  |   |
|--|---|
| <input type="checkbox"/> Lose place while reading            | <input type="checkbox"/> Hold closely to read |
| <input type="checkbox"/> Skip or re-reads lines              | <input type="checkbox"/> Print moves/jumps    |
| <input type="checkbox"/> Falls asleep reading                | <input type="checkbox"/> Eye strain           |
| <input type="checkbox"/> Blur reading                        | <input type="checkbox"/> Headaches            |
| <input type="checkbox"/> Double vision reading               | <input type="checkbox"/> Dizziness            |
| <input type="checkbox"/> Shuts one eye to read               | <input type="checkbox"/> Nausea               |
| <input type="checkbox"/> Trouble comprehending things I read |   |

Average reading time prior to the MVA/ABI? \_\_\_\_\_

Average reading time after the MVA/ABI? \_\_\_\_\_

### Hand-Eye Coordination

Please check the box if you have experienced any of the following since the time of the MVA/ABI:

- Poor hand writing/ printing
- Difficulty reaching for objects
- Reverses/ omits letters
- Difficulty catching balls

Please describe your hand-eye coordination: \_\_\_\_\_

### Distance Vision

Please check the box if you have experienced any of the following since the time of the MVA/ABI:

- |  |   |
|--|---|
| <input type="checkbox"/> Eye strain                    | <input type="checkbox"/> Double vision distance   |
| <input type="checkbox"/> Blur distance                 | <input type="checkbox"/> Trouble judging distance |
| <input type="checkbox"/> Vehicles appear in wrong lane |   |

### Lighting

Please check the box if you have experienced any of the following since the time of the MVA/ABI:

- |  |   |
|--|---|
| <input type="checkbox"/> Light sensitivity indoors     | <input type="checkbox"/> Glare of lights at night |
| <input type="checkbox"/> Light sensitivity in sunlight | <input type="checkbox"/> Light induces headache   |
| <input type="checkbox"/> Trouble seeing in dark areas  |   |

### Walking

Please check the box if you have experienced any of the following since the time of the MVA/ABI:

- |   |  |
|---|--|
| <input type="checkbox"/> Bumps into things/people                                 | <input type="checkbox"/> Trips over objects/curb |
| <input type="checkbox"/> Dizziness while moving                                   | <input type="checkbox"/> Nausea while moving     |
| <input type="checkbox"/> Lose balance while walking                               |  |
| <input type="checkbox"/> Ground does not appear level                             |  |
| <input type="checkbox"/> Need assistive device while walking (cane, walker, etc.) |  |

### Standing/Sitting

Please check the box if you have experienced any of the following since the time of the MVA/ABI:

- |   |   |
|---|---|
| <input type="checkbox"/> Feeling dizzy while still                          | <input type="checkbox"/> Objects move while still |
| <input type="checkbox"/> Incomplete image of objects                        | <input type="checkbox"/> Nausea while sitting     |
| <input type="checkbox"/> Lose balance easily                                | <input type="checkbox"/> Nausea while standing    |
| <input type="checkbox"/> Seeing objects or things that are not really there |   |

### Other

Please check the box if you have experienced any of the following since the time of the MVA/ABI:

- Loses belongings
- Easily distracted
- Poor memory/forgetful
- Poor concentration
- Dizzy while traveling (car)
- Nausea while traveling (car)
- Trouble comprehending things I see
- Trouble comprehending what I hear

If you have any specific comments or questions for the doctor please list them here: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_