alex gage
family optometrist

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SPORTS VISION QUESTIONNAIRE

*Please fill out this questionnaire **carefully** and return it to our practice **prior** to your appointment. Thank you.*

Appointment Date and Time: _____

General Information

Full name: _____ ☐Male ☐ Female

Preferred name to be called in this practice: _____

Birth date: _____ Age (years): _____(months): _____

Sports(s): _____

Address: _____ City:_____ Postcode:_____

Daytime Phone number: _____ Evening phone number: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Responsible Person Information

Home address: _____

City: _____ Postcode: _____

Home phone: _____

If a dependent, Father / Caregiver occupation:_____ Business phone: _____

Business address:_____

City: _____ Postcode: _____

If a dependent, Mother / Caregiver occupation: _____ Business phone: _____

Business address: _____

City: _____ Postcode: _____

Do you have major medical insurance? ☐No ☐ Yes If yes, which? _____

Insurer: _____ Policy #: _____

Name of insured: _____

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Sports Vision Training History

Last Eye Exam: _____ Where: _____

Do you wear vision correction? ☐No ☐ Yes, Glasses/Contacts/Both (please circle)

When do you wear your vision correction? ☐Near work only ☐ Distance only ☐Full time

Do you wear your vision correction while participating in your sport(s)? ☐ No ☐ Yes

Do you feel your current visual correction is adequate? ☐ No ☐ Yes

Medical History

Is there any history of the following? (check all that apply)

	Patient	Family	Who?		Patient	Family	Who?
Diabetes	☐	☐	_____	High blood pressure	☐	☐	_____
"Cross" or "Wall" Eye	☐	☐	_____	Learning disability	☐	☐	_____
Chromosomal imbalance	☐	☐	_____	Amblyopia (lazy eye)	☐	☐	_____
Glaucoma	☐	☐	_____	Multiple Sclerosis	☐	☐	_____
Epilepsy or seizures	☐	☐	_____				

Other (please explain): _____

Are you taking any medications? ☐ No ☐ Yes

Are you allergic to any medications? ☐ No ☐ Yes

Present Situation

Why do you feel you / your child needs a sports vision evaluation? _____

_____

_____

How long has this problem/difficulty been observed? _____

Is there any evidence from the school, psychological, or other tests that indicates some visual malfunction may be present?

☐ No ☐ Yes

If yes, what? _____

_____

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Family and Home

Do you or your family members have any significant visual problems currently or in the past? ☐ No ☐ Yes

Name	Age	Visual situation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are any of the following experienced by you/your child?

	No	Yes	If yes, when?
Headaches	☐	☐	_____
Blurred vision / focus goes in and out	☐	☐	_____
Double vision	☐	☐	_____
Eyes hurt	☐	☐	_____
Eyes tired	☐	☐	_____
Words move around on the page	☐	☐	_____
Motion sickness / car sickness	☐	☐	_____
Dizziness	☐	☐	_____
Eyes frequently reddened	☐	☐	_____
Frequent eye rubbing	☐	☐	_____
Frequent sties	☐	☐	_____
Bothered by light	☐	☐	_____
Frequent blinking	☐	☐	_____
Closing or covering one eye	☐	☐	_____
Difficulty seeing distant objects	☐	☐	_____
Tilts head when reading	☐	☐	_____
Tilts head when writing	☐	☐	_____
Moves head when reading	☐	☐	_____
Inconsistent performance	☐	☐	_____
Performs below potential	☐	☐	_____
Difficulty catching/hitting a ball	☐	☐	_____
Concentration problems	☐	☐	_____
Slow reaction time	☐	☐	_____
Overshoots or undershoots passes/throws	☐	☐	_____

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Difficulty tracking the ball	☐	☐	_____
Blurred vision	☐	☐	_____
Difficulty changing focus from near to far	☐	☐	_____
Difficulty with peripheral vision	☐	☐	_____
Awkward/poor motor coordination	☐	☐	_____
Reduced depth perception	☐	☐	_____
Closes or covers and eye	☐	☐	_____
Difficulty with fly balls	☐	☐	_____
Misses or mis-hits ball	☐	☐	_____
Affected by physical factors/fatigue/game stress	☐	☐	_____
Incomplete benefit from extra coaching or practice	☐	☐	_____
Coach's concern about inconsistent/below potential performance	☐	☐	_____

List any other vision complaints:_____

_____

_____

Give a brief description of your sport performance highlighting your strengths and weaknesses as an athlete:

_____

_____

_____

_____

_____

Please list your goals for sports vision training:

_____

_____

_____

_____

_____

Other comments:

_____

_____

_____