Dr. Taylor & Associates
5012 Dorsey Hall Drive, Suite 105
Ellicott City, Maryland 21042
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(410) 730-8878

Name: ____ DOB: _______________ Present Age: _____

Address: ______________________________________ City: ______________ State: _______ Zip:________

Home Phone: ________________ Business Phone: ____________________ Cell Phone: ________________

Occupation: _____________________________ Referred by: _______________ Email: ________________

What do you expect to find out from the evaluation? ____

How did you perform in school? □ Average □ Above Average □ Below Average
Do you play sports? □ Yes □ No Type & Amount: ____
Other Form of exercise: ____
Do you have any hobbies: ____
How many hours per day do you use: Computer ______Read ______ Watch TV ______ Play video games ________
Are there any activities that you would enjoy doing, but must restrict because of your vision? □ Yes □ No
Please explain: ____

………

Present Situation:
In what ways are you having visual difficulty? ____
How long have you noticed this difficulty? ____

Have you been diagnosed with a concussion? □ Yes □ No Date of injury? __________________________

Previous visual examinations*:*

Reason for evaluation	Doctor's Name	Date	Result

Have you or anyone else ever noticed an eye turn in or wander out? □ Yes □ No Which eye? _______________
At what age was it first noticed? ___________ Have you had eye surgery? □ Yes □ No ___________________

Do you ever experience any of the following?

Headaches	□ Yes	□ No	When? _________	Eyes hurt or tired	□ Yes □ No	When? _________
Blurred vision @ far	□ Yes	□ No	When? _________	Double Vision	□ Yes □ No	When? _________
Blurred vision @ near	□ Yes	□ No	When? _________	Light Sensitivity	□ Yes □ No	When? _________

Have you ever noticed the following?

Holding reading material too close	□ Yes	□ No	Difficulty with short term memory	□ Yes	□ No
Holding reading material far away	□ Yes	□ No	Difficulty with long term memory	□ Yes	□ No
Tilting head when reading	□ Yes	□ No	Short attention span	□ Yes	□ No
Bumping into objects	□ Yes	□ No	Difficulty attending to details	□ Yes	□ No
Closing/covering one eye when reading	□ Yes	□ No	Difficulty driving	□ Yes	□ No
Excessive eye rubbing	□ Yes	□ No	Get lost in book; Unaware peripherally	□ Yes	□ No
Experience fatigue quickly when reading	□ Yes	□ No	Avoid sports	□ Yes	□ No
Lose place when reading	□ Yes	□ No	Motion sickness	□ Yes	□ No
Using finger to keep your place when reading	□ Yes	□ No	Dizzy Spells	□ Yes	□ No

Health /Family History
Please check the conditions that apply to you or that run in your family:

Systemic Disease/Condition

	Yes	No	Relationship
Arthritis	□	□	____________
Rheumatoid arthritis	□	□	____________
Fever	□	□	____________
Weight loss/gain	□	□	____________
Cancer	□	□	____________
Diabetes	□	□	____________
Drug sensitive	□	□	____________
Elevated cholesterol	□	□	____________
Heart disease	□	□	____________
High blood pressure	□	□	____________
Thyroid disease	□	□	____________
Migraine	□	□	____________
Skin (acne, cancer)	□	□	____________
Gastrointestinal	□	□	____________
Urogenital (kidney, bladder)	□	□	____________
Neurological (MS, seizures)	□	□	____________
Psychiatric (depression, etc)	□	□	____________
Allergies	□	□	____________
Respiratory			
asthma	□	□	____________
emphysema	□	□	____________
bronchitis	□	□	____________
Kidney disease	□	□	____________

Ocular Disease/Condition

	Yes	No	Relationship
Lazy eye	□	□	____________
Color "blind"	□	□	____________
Light sensitive	□	□	____________
Eyestrain	□	□	____________
Dry Eyes	□	□	____________
Floaters/Spots	□	□	____________
Flashing lights	□	□	____________
Retinal detachment or retinal disease	□	□	____________
Blindness	□	□	____________
Macular degeneration	□	□	____________
Cataracts	□	□	____________
Crossed eyes	□	□	____________
Glaucoma	□	□	____________
Head trauma	□	□	____________
Eye Surgery	□	□	____________

Date of last physical: ________________

How is your general health? □ Excellent □ Good □ Fair □ Poor _____________________________

Are you currently under a physician's care? □ Yes □ No
Drs. name: ____

Are you taking any medications? □ Yes □ No
If so, please list: ____

List any major illness:	Age	Mild	Severe
________________	____	____	____
________________	____	____	____
________________	____	____	____
________________	____	____	____

We are looking forward to meeting you and helping you meet your visual needs.

I authorize the release of medical and/or other information pertinent to my care to the insurance company in order for me to be reimbursed.

Signature: ____ Date: ____________________