Academy of Vision and Learning, Optometry
Qiaoqiao Wang O.D., Ph.D

Welcome to Academy of Vision and Learning, Optometric vision therapy

Thank you for choosing our office for your vision care. You will soon be coming for a functional vision evaluation. This evaluation includes tests for glasses prescription, eye coordination and eye tracking and other visual concerns base on your history. The appointment should last 1.5 hour.

We work closely with your primary eye doctor to deliver the best vision care. If you had an eye exam before, please have your eye doctor fax the medical record to our office at 203 738-0523.

Please fill out the enclosed history forms and the symptoms checklist as accurate as possible before the appointment. Because this information is very important to make treatment plan later. You may email or fax it to us prior to your appointment or bring it with you. Copies of previous evaluation and reports may be faxed or brought with you.

Please bring any eyeglasses and/or contact lenses prescription with you.

Insurance and payment

In order to provide this premium individualized program of vision care, our office is not affiliating any insurance plan and provide service on a private pay basis only. The fee for the testing is $285. This fee also includes consultation and report. Payment will be expected in full at the time of service. Your insurance plan may cover the services and we encourage you to seek reimbursement. We will provide you with a detailed receipt to submit to your insurance company. You may also use your Flexible spending account and Health saving account for the service.

Reasons for the appointment (check all, which apply)

___work related vision problem

___eye teaming problem (turned eye lazy eye)

___myopia control/reduction

___sports vision enhancement

___vision problems after brain injury

2514 Boston Post Road, Guilford, CT 06437 Phone 203-453-4813 Fax 203-738-0523
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HISTORY FORM FOR BINOCULAR VISION PROBLEMS

Please provide the following information as completely as possible. Use the back side of page if needed.

Name (Last, First, MI) _____DOB_____ Date: _____

Address_____

Phone number: _____E-mail: _____

Occupation_____ if you are in school, which school_____

How did You Hear About us? _____ Referred by _____

Primary care physician Name/Address _____

Last physical examination _____ Allergies _____

Present medications_____

Last eye examination_____ Any eye injury or eye surgery? _____

Any family members have vision problems?

Present Situation:

What do you expect to find out from the exam?

Do you have any special concerns regarding your vision?

Is there any history of head injury, falls, accidents or serious wounds in the head/neck/back area? If so please describe.

Lifestyle information:

Do you spend time on a computer? ____ hours/ day
Are you sensitive to light, glare, reflection? Yes No Comments
Are you participate in sports? Yes No Comments
Do you read for pleasure? Yes No Comments
Do you spend time using small screen devices? (smart phone, tablet) ____hours/day

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Visual History

In what way do you seem to have visual difficulty?

_____

How long has visual difficulty been noticed?

_____

Has anyone noticed an eye turn in or wander out? _____Which? _____

Do you ever experience: Headaches □Yes □No When? _____

Double Vision □Yes □No When? _____

Blurred Vision Far □Yes □No When? _____

Eyes hurt or tired □Yes □No When? _____

Blurred at Near □Yes □No When? _____

Have you ever noticed:

Holding reading close? □Yes □No

Tilting head when reading? □Yes □No

Holding reading further away? □Yes □No

Bothered by light? □Yes □No

Closing one eye? □Yes □No

Inability to see distance objects? □Yes □No

Covering one eye? □Yes □No

Bumping into objects? □Yes □No

Eyes frequently reddened? □Yes □No

Poor general coordination? □Yes □No

Frequent styes? □Yes □No

Excessive eye rubbing? □Yes □No

Get lost in book? □Yes □No

Have you ever had vision therapy? □Yes □No

Has there been previous visual care? _____ If so, please detail below:
Doctor's Name Approximate Date diagnosis

Please list family members who have any visual conditions, learning problems or similar medical conditions.
Name and Relationship Age (now) Visual, learning or medical condition (age it began)

_____

_____

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Your Health History

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

Did you have Traumatic Brain Injury or Stroke or concussion □ Yes □No

How is your diet? □Healthy and balanced diet □Poor and need to improve

Please check the conditions that apply to you or that run in your family:

Systemic Disease/Condition	Yes	No	Relationship
Arthritis	□	□	_____
Diabetes	□	□	_____
Rheumatoid Arthritis	□	□	_____
Fever	□	□	_____
Weight loss/gain	□	□	_____
Cancer	□	□	_____
Diabetes	□	□	_____
Drug sensitive	□	□	_____
Elevated cholesterol	□	□	_____
Heart problem/disease	□	□	_____
High blood pressure	□	□	_____
Thyroid	□	□	_____
Migraine or Headaches	□	□	_____
Skin (acne, cancer)	□	□	_____
Gastrointestinal	□	□	_____
Urogenital (kidney, bladder)	□	□	_____
Neurological (MS, seizures)	□	□	_____
Psychiatric (depression, etc.)	□	□	_____
Respiratory (asthma, bronchitis, emphysema)	□	□	_____

Ocular Disease/Condition	Yes	No	Relationship
Lazy eye	□	□	_____
Turned 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	□	□	_____

Is there any other information that would be helpful/important in our evaluation or treatment of your vision?

As you complete this history questionnaire you will recognize the thoroughness with which your problem will be considered. The office examination will take up enough time to permit a very complete optometric investigation of any problem. I am 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 other providers who referred me.

Signature: _____Date: _____

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Insurance Plans

Please note, Dr. Wang is not affiliated with any insurance plan and provides service on a private pay basis only. Payment is expected in full at the time of service. Check, cash, or credit card accepted. Your insurance company may cover our services and we encourage you to seek reimbursement. We will provide you with a detailed receipt you may submit with your insurance claim.

Signature: _____ **Date:** _____

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