ornelius J. Mietus, O.D.

VISION THERAPY SANTA BARBARA

3710 State Street, Suite C, Santa Barbara, CA 93105 805.969.2020

PATIENT____________________________date of birth________today's date______

RESPONSIBLE PARTY____

MAILING ADDRESS____

CITY_____________________________________STATE__________ZIP_________

EMAIL____

PHONE____

REFERRED BY____

REPORT TO DOCTORS yes/no____

____

CONCUSSION, TRAUMATIC BRAIN INJURY or STROKE: date of injury___________

Details of event____

____

MEDICAL HISTORY

Previous diagnosis, chronic illness, medications_________________________________

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THERAPEUTIC HISTORY (physical therapy, occupational therapy)________________________

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VISUAL HISTORY previous exams, glasses, contacts, vision therapy____________________

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OBSERVATIONS AND SYMPTOMS: Please mark all that apply

( ) dizziness
( ) vertigo, please describe_____________________________________
( ) motion-sickness, please describe______________________________
( ) looks like thing are in motion but they are not
( ) double vision, please describe_________________________________
( ) blurred or confused vision
( ) reading problems
( ) eyestrain
( ) headaches, please describe___________________________________
( ) poor balance
( ) difficulty walking straight
( ) difficulty standing
( ) bothered by bright light
( ) bothered by sounds
( ) loss of ability to do mental math
( ) poor sense of direction
( ) poor handwriting
( ) rapid visual fatigue when reading
( ) close one eye to see better

Please tell me other ways that the injury has affected you
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