ORANGEVILLE VISION DEVELOPMENT CENTRE

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SPORTS VISION

PATIENT INFORMATION

Name: _____ Male / Female

Date of Birth: _____ (M/D/Y) Age: _____

Address: _____

City: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Referred by: _____

Health Card #: _____ Version Code: _____

Sport: _____ # of hours playing sport(s) each day: _____

Team/Club: _____ Coach/Athletic Trainer(s): _____

_____ _____

MEDICAL HISTORY

Date of most recent medical exam: _____ Doctor's Name: _____

Reason: _____

Results: _____

Have you had a sports injury in the last year? YES / NO If YES, please explain:

_____

Past surgical history: _____

Medications/Vitamins/Supplements:_____

_____

Allergies: _____

Chronic Problems (ie. ear infections, asthma): _____

Any current or past Physical Therapy? YES / NO If YES, please explain:

_____

Have you had a concussion? YES / NO If YES, how many, when & how:

_____

_____

Any history of the following?	Self	Family	COMMENT
Eye Turn (Strabismus)	☐	☐	_____
Lazy Eye (Amblyopia)	☐	☐	_____
Double Vision (Diplopia)	☐	☐	_____
High Prescription	☐	☐	_____
Learning Disabilities	☐	☐	_____
Eye Shake (Nystagmus)	☐	☐	_____
ADD/ADHD	☐	☐	_____
Colour Blindness	☐	☐	_____
Glaucoma	☐	☐	_____
Seizures	☐	☐	_____

VISUAL HISTORY

Date of last eye exam: _____

Optometrist: _____

Do you wear glasses for driving, sports, television, computer, reading?

_____

How old were you when you received your fist pair of glasses?

_____

Do you ever wear contact lenses? YES / NO If YES, what kind/brand of lenses do you wear?

_____

How many hours a day do you wear your contact lenses?

_____

Any eye injuries or eye surgeries? YES / NO If YES, when and describe:

_____

Do you feel your vision is affecting your sports performance?

_____

Do you experience any of the following?	YES	NO	COMMENT/WHEN
Blurry distance vision	☐	☐	_____
Blurry near vision	☐	☐	_____
Double Vision (Diplopia)	☐	☐	_____
Itchy Eyes	☐	☐	_____
Watery Eyes	☐	☐	_____
Headaches around eyes, forehead & temple	☐	☐	_____
Dizziness	☐	☐	_____
Nausea	☐	☐	_____
Light Sensitivity	☐	☐	_____

SPORT HISTORY

What position(s) do you play? _____

If applicable, what hand do you throw with? Right Left Both

If applicable, which way do you bat/swing? Right Left Switch

If applicable, which foot do you kick with? Right Left Both

If applicable, which way do you shoot a puck? Right Left Both

Do you have a visual plan when or before you compete? YES / NO

Do you do any visual warm activities? YES / NO

Can you visualize plays/strategies in your head during a game? YES / NO

Do you have any problem with balance? YES / NO

Is your overall sports performance as consistent as you would like? YES / NO

Is the level of your performance consistent throughout a game? YES / NO

Does your performance decrease with pressure? YES / NO

Does your performance increase under pressure? YES / NO

Does any of the following interfere with or affect your performance? (check all that apply):

□ Bright sun □ Dim light □ Without glasses

□ With sunglasses □ Busy background □ Crowd movement

□ Player movement □ Crowd noise □ Rain

□ Uniform colours

Do you feel you are playing to your potential? YES / NO If NO, please describe:

_____

_____

What areas would you like to improve?

□ Tracking a ball/puck □ Visualization/Memory □ Concentration

□ Reaction Time □ Depth Perception □ Attention Focus

□ Peripheral Awareness □ Judging Distance □ Judging Speed

□ Consistency in Performance □ Eye-Hand Coordination □ Decreasing Distractibility

If not listed above, list any areas you would like to improve in your game:

_____