HELLERSTEIN & BRENNER
VISION CENTER, P.C.

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SUPPLEMENTAL CASE HISTORY

Please fill out as much of this form as possible. Have your family, therapists and other physicians help if necessary. Bring this form to your initial vision appointment.

Name: _____ Date: _____

Description of trauma/illness: Car accident Fall Hit by object Toxic Anoxic Illness

CVA: Stroke, aneurysm, hemorrhage Other: _____

_____ Date of trauma: _____

Reason for referral: _____

Initial care: Hospital _____

Subsequent/other professional care (name & date of treatments):

Family physician _____

Neurologist _____

Chiropractor/Osteopath _____

PT/OT/Speech _____

Physiatrist _____

Optometrist _____

Ophthalmologist _____

Symptoms:

Dizzy _____ Nausea _____

Disorientation _____ Objects move _____

Balance _____ Bumps into things _____

Light sensitivity _____ Restricted field _____

Memory _____ Poor attention/concentration _____

Reading (loss place, fatigue, comprehension)

Difficulties following accident/trauma:

Work related _____

Hobbies _____

Recreation _____

Other

Form completed by: _____ Date: _____

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