HELLERSTEIN & BRENNER
VISION CENTER, P.C.

TRICIA BRENNER, O.D. • SHELBY RILEY, O.D. • SARA GRELL, O.D. • KYARA FARINELLA, O.D. • AMY OVERLAND, O.D.

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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