DR. RICK THOMPSON
DR. GREG THOMPSON

Developmental, Rehabilitative & General Optometry

470 Chrysler Drive, Unit #3 P: 905-793-2020
Brampton, ON L6S 0C1 F: 905-793-8528

Instructions for Using Online Forms

1. Open file in browser (click on form link)
2. Save to desk top
3. Fill in blue area on downloaded copy
4. Under printers, if you can, save as pdf and save somewhere on your computer where you can locate it easily
5. Email the filled in form to contact@drrickthompson.ca (attach form to email) OR
6. Print the filled in form directly from your browser and fax to (905) 793-2020

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HEAD INJURY/ABI PATIENT INFORMATION

Full Name:_____ Date of Birth (mm/dd/yy): _____

Home Address: _____ OHIP #: _____

City: _____ Postal Code: _____ Phone Number: _____

Emergency Contact: _____ Relationship: _____

Date of Loss: _____

Email Address: _____

How did you hear about us? _____

HEALTH HISTORY

Family Doctor: _____

Any Hospitalizations: _____

List of Medications: _____

_____

Do you have any allergies? ☐ Yes ☐ No

If so, please list them here: _____

_____

(list on back if needed)

Please check the box if you have any history of the following:

☐ Glaucoma
☐ Cataracts
☐ Retinal Detachment
☐ Macular Degeneration
☐ Colour Blindness

☐ Diabetes
☐ Stroke
☐ Asthma
☐ Arthritis
☐ Heart Problems
☐ Thyroid Condition
☐ Allergies
☐ High Blood Pressure

Do any of the listed items above run in your family? If so, please list them here: _____

_____

_____

_____

VISION/MVA RELATED QUESTIONS

Is this your first visual examination? ☐ Yes ☐ No
If not, when was your last examination? _____

Have you had any eye injuries in the past? ☐ Yes ☐ No
If so, please explain: _____

Have you had any eye surgeries? ☐ Yes ☐ No
If so, please explain: _____

Please check the box if you have experienced any of the following at the time of the MVA/ABI:

☐ Eye Injury
☐ Closed head injury
☐ Whip lash
☐ Unconscious
☐ Physiotherapy
☐ CT scan
☐ MRI
☐ Cranial Sacral Therapy
☐ Chiropractic Therapy

Please check the box if you get overwhelmed or anxious in any of the following situations:

☐ Big box stores
☐ In large groups/ crowds
☐ Driving
☐ Public transit
☐ Around loud noises

Do you currently have a valid driver's license? ☐ Yes ☐ No
Has your driver's license ever been suspended? ☐ Yes ☐ No

Do you work currently (part time or full time)? ☐ Yes ☐ No
If not, what barriers prevent you from working? _____

_____

_____

_____

VISUAL SIGNS & SYMPTOMS

PHYSICAL

Please check the box if you have experienced any of the following since the time of the MVA/ABI:

- ☐ Dry eyes
- ☐ Burning eyes
- ☐ Watery eyes
- ☐ Itchy eyes
- ☐ Rubbing eyes
- ☐ Squinting
- ☐ Eye drops
- ☐ Eye turn
- ☐ Wandering eye
- ☐ Eye pain
- ☐ Flashes/spots in vision

Do you experience headaches? ☐ Yes ☐ No
If so, please explain: _____

_____

Reading

Please check the box if you have experienced any of the following since the time of the MVA/ABI:

- ☐ Lose place while reading
- ☐ Skip or re-reads lines
- ☐ Falls asleep reading
- ☐ Blur reading
- ☐ Double vision reading
- ☐ Shuts one eye to read
- ☐ Hold closely to read
- ☐ Print moves/jumps
- ☐ Eye strain
- ☐ Headaches
- ☐ Dizziness
- ☐ Nausea
- ☐ Trouble comprehending things I read

Average reading time prior to the MVA/ABI? _____

Average reading time after the MVA/ABI? _____

Hand-Eye Coordination

Please check the box if you have experienced any of the following since the time of the MVA/ABI:

- ☐ Poor hand writing/ printing
- ☐ Difficulty reaching for objects
- ☐ Reverses/ omits letters
- ☐ Difficulty catching balls

Please describe your hand-eye coordination: _____

_____

Distance Vision

Please check the box if you have experienced any of the following since the time of the MVA/ABI:

- ☐ Eye strain
- ☐ Blur distance
- ☐ Vehicles appear in wrong lane
- ☐ Double vision distance
- ☐ Trouble judging distance

Lighting

Please check the box if you have experienced any of the following since the time of the MVA/ABI:

- ☐ Light sensitivity indoors
- ☐ Light sensitivity in sunlight
- ☐ Trouble seeing in dark areas
- ☐ Glare of lights at night
- ☐ Light induces headache

Walking

Please check the box if you have experienced any of the following since the time of the MVA/ABI:

- ☐ Bumps into things/people
- ☐ Dizziness while moving
- ☐ Lose balance while walking
- ☐ Ground does not appear level
- ☐ Need assistive device while walking (cane, walker, etc.)
- ☐ Trips over objects/curb
- ☐ Nausea while moving

Standing/Sitting

Please check the box if you have experienced any of the following since the time of the MVA/ABI:

- ☐ Feeling dizzy while still
- ☐ Incomplete image of objects
- ☐ Lose balance easily
- ☐ Seeing objects or things that are not really there
- ☐ Objects move while still
- ☐ Nausea while sitting
- ☐ Nausea while standing

Other

Please check the box if you have experienced any of the following since the time of the MVA/ABI:

- ☐ Loses belongings
- ☐ Easily distracted
- ☐ Poor memory/forgetful
- ☐ Poor concentration
- ☐ Dizzy while traveling (car)
- ☐ Nausea while traveling (car)
- ☐ Trouble comprehending things I see
- ☐ Trouble comprehending what I hear

If you have any specific comments or questions for the doctor please list them here: _____

_____

_____

_____

_____