Questionnaire: Athletes

CONTACT INFORMATION

Last Name, First Name	Birth date
Address	Postal Code, City
Telephone	Cell Phone
Email	Website

Which Sport do you play?

At what age did you begin playing this sport?

Trainer's name:

Or Teacher's name: Grade/Level:

List your hobbies:

Who referred you to us?

This questionnaire is specifically designed for athletes. It is used to evaluate your vision and visual ability. Our goal is to help you use all of your visual potential. Please answer the following questions with as much detail as possible. If you feel there is any ambiguity, please contact me and I will gladly clarify your questions and concerns.

MEDICAL BACKGROUND

Are you currently receiving medical treatment? YES / NO, If YES: since when?

What is the name of medical provider:

What is the diagnosis?

What is the name of your Sports Medicine provider? Since when:

What is the date of your last sports medical examination?

Who performed your last sports medical examination?

What were the results?

Are you RIGHT or LEFT handed?

Are you RIGHT of LEFT footed?

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EYESIGHT

Do you have any vision problems? YES / NO, If YES, Please describe:

Do you have a family member who has a vision condition? YES / NO, If YES, what is your relationship?

Please list the vision conditions.

Have you been treated by an Ophthalmologist? YES / NO, If YES, then answer the following:

First Test: Date	Name of doctor:
Latest Test: Date	Name of doctor:

What were the results?

Do you wear glasses: YES / NO, If YES, since when?

Name of prescriber:

Do you wear sports glasses? YES / NO

Do you wear contact lenses? YES / NO

If YES, please answer the following:

Since when?	Who measured the prescription for the lenses?

Are you wearing your lenses today? YES / NO

What type of contact lenses do you wear? Soft Contact Lenses / Hard Contact lenses

Disposable: MONTHLY / 2 WEEK / DAILY

Which cleaning solution do you use?

Do you wear your contact lenses for sports? YES / NO

Do you wear your contact lenses when sleeping? YES / NO

When was your last contact lenses checkup?

Name of doctor/ practitioner:

Please describe any problems you have with the contact lenses you are currently wearing.

If NO, please answer the following:

If you currently don't wear contact lenses, have you ever worn them? YES / NO,

If YES, Why did you stop wearing them?

WHILE PLAYING SPORTS

Is your vision always unclear? YES / NO, If YES, CLOSE UP or DISTANCE?

YES OFTEN SOMETIMES DON'T KNOW NO

Is your vision unclear when playing sports?

Does your vision change while playing sports?

Please describe any blurred vision while playing sports.

Do you sometimes experience double vision? YES / NO, IF YES :

At what distance does your vision blur? CLOSE UP / MID- DISTANCE / LONGER DISTANCE

Does the double vision occur while you are playing sports? YES / NO

When do you notice you have double vision?

Have you ever found it difficult to focus on a moving object (e.g a ball)? YES / NO, If YES: Please describe a specific example when this occurred.

Do you notice any changes (fluctuations) in your vision? (e.g. during a game, running etc.) YES / NO

When Is your vision most stable during competitions? BEGINNING OF MATCH / MID- MATCH / IN THE LAST THIRD / ALWAYS CONSISTENT

Does your vision remain stable in critical situations during competition? YES / NO

Is your vision stability affected when you compete in the daytime versus the nighttime? YES / NO

Do you….

YES OFTEN SOMETIMES DON'T KNOW NO

Reverse numbers? (e.g. 78 and 87)

Reverse letters? (e.g b&d, p&q, m&n, etc)

Have difficulty seeing drawings and numbers indoors?

Reverse LEFT and RIGHT?

Have sensitivity to light, even in normal ambient lighting?

Have difficulty maintaining concentration?

Do you experience burning or itchy eyes when looking at objects close up?

Has your hearing been tested? YES / NO, If YES: When?

What is the name of the practitioner who tested your hearing?

What were the results of the test?

Do you suffer from allergies? YES / NO, If yes, when?

Which ones?

Please describe your symptoms.

Do you suffer from any chronic illness? YES / NO, If YES, when?

Please list chronic illnesses.

Please list your current injuries:

Have you ever had an operation? YES / NO, If YES, When?

Please list operations and diagnosis.

Are you currently taking any medication? YES / NO, If YES, since when?

Please list medications.

Please list any food supplements you take.

Who prescribed/recommended these?

Other comments:

Thank you for your cooperation!

City, Date **Signature**