Gleneagle Vision Center

Brain Injury, Stroke, and Vision

Vision difficulties are one of the most common symptoms experienced by brain injury and stroke patients. Even a minor incident can lead to severe symptoms, including:

- Blurry vision at distance and/ or near
- Difficulties with concentration and cognition
- Headaches
- Sensitivity to light and sunshine
- Anxiety in crowded spaces
- Trouble going up and down stairs
- Seeing words or print move on the page
- Difficulties with balance and poor posture
- Being easily fatigued
- Double vision
- Difficulty driving
- Bumping into doorways or walls

Often, patients will have their eyes examined only to be told that there is nothing wrong with their eyes. That is because the underlying problem occurs in the midbrain, not in the eyes. Traditional eye exams only check the focus (focal visual system) and the health of the eyes. A complete neuro-optometric examination also tests the function of the ambient visual system, which arises in the midbrain.

There are two basic visual systems in humans, the **ambient visual system** and the **focal visual system**. In order to see clearly and efficiently, the two systems must work together. The ambient visual system acts as an anchor, stabilizing the pictures being sent from the two eyes to the brain. This stabilization in turn allows the brain to merge the two images into one clear, stable image; the focal visual system. Without the anchor of the ambient system, the eyes are left to drift, and the brain has great difficulty merging the two images. This in turn causes many of the symptoms experienced by brain injury and stroke patients listed above.

A complete neuro-optometric exam includes a thorough evaluation of the ambient visual system as well as the focal system. If an inefficiency between the two systems is found, treatment strategies can often be prescribed to reduce or eliminate the troublesome symptoms. If you or someone you know is experiencing problems after a brain injury or stroke, please call to schedule an appointment today.

Michael Saxerud, O.D. is a member of NORA (Neuro-Optometric Rehabilitation Association) and has been successfully treating brain injury and stroke patients since 2006.

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Gleneagle Vision Center, P.C.
Registration Form

Patient Information

Patient's Legal Name:_____ **Suffix:**_____ **Today's Date:**_____

Nick Name:_____ **Sex:** ☐M ☐F **Title:** ☐Mr. ☐Ms. ☐Mrs. ☐Miss

Date of Birth:_____ **Age:**_____ **SS#** (for billing purposes):_____

Street Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Home Phone #:_____ **Cell Phone #:** _____

Work Phone #: _____ **Email:**_____

Preferred Contact (circle one): Cell Home Email Other_____

Insurance Information

Primary Medical Insurance:_____

Subscriber Name:_____ **Date of Birth:**_____

SS# (for billing purposes):_____ **Policy #:**_____ Group # (optional):_____

Relationship to Subscriber (circle one): Self Spouse Child Other_____

Secondary Medical Insurance:_____

Subscriber Name:_____ **Date of Birth:** _____

SS# (for billing purposes):_____ **Policy #:**_____ Group # (optional):_____

Relationship to Subscriber (circle one): Self Spouse Child Other_____

Vision Insurance (circle one): **VSP** **EYEMED**

Subscriber Name:_____ **Date of Birth:**_____

SS# (for billing purposes):_____ **Policy #:**_____ Group # (optional):_____

Relationship to Subscriber (circle one): Self Spouse Child Other_____

Release of Information

I authorize the release of information (including the diagnosis, records, examination rendered to me and claims information) to be released to the following*:

☐Spouse:_____ ☐Other:_____

☐Child(ren):_____ ☐**DO NOT** release my information to anyone

Messages

If unable to reach me:

☐You may leave a detailed message

☐You may leave a brief message asking for a call back

*The release information and method to reach me will remain in effect until terminated by me in writing.

Patient/Guardian Signature:_____ Date:_____

Gleneagle Vision Center, P.C.
Medical Questionnaire

Name:_____ Date:_____

Reason for Visit:

☐General Eye Exam ☐General Eye Exam with Contacts Lens Fitting/Evaluation

☐Evaluation after Trauma/Brain Injury/Concussion/Stroke/Neurological Reason

☐Referral from-_____

☐Other_____

Do you wear glasses? Yes No Do you wear Contacts? Yes No
Type of Contacts: Soft Other

Date of Last Eye Exam:_____ Eye Doctor:_____
Last Medical Exam:_____ Primary Care Physician:_____

Medical History

Current Medications: including contraceptives, over the counter, supplements, vitamins:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies to Medications? Yes No If yes,_____

List any major injuries/motor vehicle accidents/concussions/surgeries/hospitalizations with dates:

_____
_____

Are you pregnant or nursing? Yes No

Social History

Do you drive? Yes No Is driving difficult? Yes No
Do you use any tobacco products (circle one)? >1 year 1-5 years <5-10 years Occasional Never
Do you consume alcohol (circle one)? Occasional Frequent Never
Do you use any recreational drugs (circle one)? Occasional Frequent Never
Have you ever been exposed to or infected with: AIDS/HIV Gonorrhea Hepatitis Syphilis None
Hobbies/Sports:_____
Occupation:_____

☐ I would prefer not to discuss my social history.

Review of Systems

Do you currently, or have you ever had problems in the following areas?

Constitutional
Yes No Fever, weight gain/loss
Ear/Nose/Throat
Yes No Sinus Congestion
Yes No Dry mouth/throat

Cardiovascular
Yes No Heart Pain
Yes No High blood pressure
Yes No Vascular disease
Yes No Heart surgery

Respiratory
Yes No Asthma
Yes No Chronic bronchitis
Yes No Emphysema

Genitourinary
Yes No Dialysis/kidney failure

Gastrointestinal
Yes No Diarrhea
Yes No Constipation

Musculoskeletal
Yes No Rheumatoid arthritis
Yes No Muscle pain
Yes No Joint Pain

Integumentary (Skin)
Yes No Eczema
Yes No Skin cancer
Yes No Sinus Congestion

Neurological
Yes No Headaches
Yes No Migraines
Yes No Concussion
Yes No Stroke

Psychiatric
Yes No Depression
Yes No Anxiety

Endocrine
Yes No Diabetes
Yes No Hyper/Hypo thyroid

Hematologic/Lymphatic
Yes No Anemia
Yes No Bleeding problems

Allergic/ Immunologic
Yes No Lupus
Yes No Hay fever/allergies

Please explain if you have answered yes to any of the conditions above or have any conditions not listed:

_____

_____

Ocular History

Yes No Glaucoma
Yes No Cataracts
Yes No Diabetic Retinopathy
Yes No Retinal Disease
Yes No Eye Injury
Yes No Blindness
Yes No Cross/turned eye
Yes No Lazy eye/amblyopia
Yes No Keratoconus

Yes No Decreased vision
Yes No Dry eyes
Yes No Burning eyes
Yes No Itching eyes
Yes No Double vision
Yes No Eye pain
Yes No Floaters
Yes No Flashes of light
Yes No LASIK/other eye surgeries

Please explain if you have answered yes to any of the conditions above or have any conditions not listed:

_____

_____

Family History

			Relationship
Blindness	Yes	No	_____
Cataract	Yes	No	_____
Glaucoma	Yes	No	_____
Macular Degeneration	Yes	No	_____
Retinal Detachment	Yes	No	_____
Cancer	Yes	No	_____
Diabetes	Yes	No	_____
Heart Disease	Yes	No	_____
High Blood Pressure	Yes	No	_____

☐ **Unknown Family History**

Visual Symptoms

Patient Name:_____ Today's Date:_____

Referred by:_____ Injury Date:_____

Directions: For each of the following questions, please check the answer that best describes your situation **with your current glasses on.** If any of the following were experienced **prior** to your injury, please place a check mark in the **last column as well.** Daily = Everyday Frequently = At least 1 time per week Occasionally = Less than 1 time per week Never	√ DAILY	√ FREQUENTLY	√ OCCASIONALLY	√ NEVER	√ EXISTED BEFORE INJURY
Do you experience headaches?					
Do you experience double vision or overlapping (ghost) images?					
Do you experience blurry vision at distance?					
Do you experience blurry vision at near?					
Do words move around the page when you try to read?					
Do your eyes tire easily while reading or using the computer?					
Do you blink frequently to clear your vision?					
Do objects appear suddenly in your peripheral vision?					
Do you experience dizziness or vertigo?					
Do you have difficulties with your balance?					
Do you drift to the left or right while walking?					
Do you have difficulties with stairs or uneven ground?					
Do you have neck or shoulder pain/discomfort?					
Do you experience discomfort in crowded spaces?					
Does riding in a car cause uneasiness or anxiety?					
Do you have difficulties driving a car?					
Are you sensitive to sunlight?					
Are you sensitive to indoor lights?					