Gleneagle Vision Center

Injury Information

Patient Name:_____ Date:_____

Please briefly describe the injuries or accident that have led to your current vision problems:

_____

_____

_____

_____

Did you lose consciousness? ☐ Yes ☐ No

If so, for how long?_____

Please check if this was a:

☐ Motor Vehicle Accident ☐ Sports Concussion ☐ Other

If this was a motor accident,

Were you a: ☐ Driver ☐ Passenger ☐ Pedestrian

Were you on a: ☐ Highway ☐ Street ☐ Parking lot

If you were on a highway,

Were you: ☐ Entering ☐ Exiting ☐ On the highway

Were you: ☐ Moving ☐ Stopped

When did you begin to notice difficulties with your vision? _____

Please list all previous injuries, concussions, surgeries, or motor vehicle accidents including the year of the occurrence:

_____

_____

_____

_____

Has a vision/eye exam been performed since the injury? ☐ Yes ☐ No

If yes, by whom?_____ Date:_____

Doctor Recommendations?_____

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