

**John C. Metzger, OD**  
**Kansas City Vision Performance Center**  
10875 Grandview Dr., Ste. 2260, Overland Park, Kansas 66210  
(913) 469-8686 www.kcvisionperformance.com

**Adult History Form**

**GENERAL INFORMATION**

Full Name \_\_\_\_\_ Goes by: \_\_\_\_\_

Street Address: \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

DOB: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Email: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Spouse's Occupation: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

How did you hear about our center? \_\_\_\_\_

**PRESENT SITUATION**

Why do you wish to be evaluated? \_\_\_\_\_

List any complaints you have concerning your vision: \_\_\_\_\_

At what age did the problem begin and under what circumstances: \_\_\_\_\_

Has the problem become better or worse? \_\_\_\_\_ Explain: \_\_\_\_\_

Does anyone else in the family have a similar problem? \_\_\_\_\_

**MEDICAL HISTORY**

List any illnesses, seizures, accidents, surgeries, fevers, etc that you have experienced:

Illness/Injury	Age	Type of Severity	Complications (if any)

List any prescription or over-the-counter medication(s) being taken, dosage, name reason:

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Health at present:    **Excellent**    **Good**    **Fair** **Poor**

When was your last eye exam? \_\_\_\_\_

Clinic name and address: \_\_\_\_\_

Were glasses recommended at any of your previous vision examination(s)?    Yes    No

Were treatment recommendations made?    Yes    No    If yes, explain: \_\_\_\_\_

Was the treatment program followed?            Yes    No

Was the treatment effective?    Yes    No

Has a vision therapy program ever been recommended?    Yes    No

    o    If yes has the program been completed?            Yes    No

Members of the family who have had vision treatment and why?

Name	Age	Visual Condition/Treatment

List any complications or abnormalities surrounding your mothers' pregnancy and your birth:

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List any developmental delays as a child (crawling, walking, etc): \_\_\_\_\_

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**EDUCATIONAL HISTORY**

Highest grade completed in school: \_\_\_\_\_ Did you enjoy school?    YES    NO

Specifically describe any school difficulties you experienced: \_\_\_\_\_

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Do you like to read?    Yes    No

Would you rather be read to than read by yourself?    Yes    No

What do you enjoy reading? \_\_\_\_\_

Have you ever been classified as ADD, ADHD, LD, dyslexic, or any other diagnosis?    Yes    No

If so, what? \_\_\_\_\_

Are you taking any medication for any of these conditions?: YES NO  
If so, what? \_\_\_\_\_  
\_\_\_\_\_

**INTERESTS AND HOBBIES**

What hobbies and activities do you most enjoy? \_\_\_\_\_  
\_\_\_\_\_

What hobbies and activities do you least enjoy? \_\_\_\_\_  
\_\_\_\_\_

Are you involved in any organized sports activities or teams? YES NO  
If so, what? \_\_\_\_\_

Do you enjoy music? YES NO Do you play a musical instrument? YES NO  
If so, what? \_\_\_\_\_

Can you carry a tune? YES NO Can you maintain rhythm when dancing? YES NO

Briefly describe your personality: \_\_\_\_\_  
\_\_\_\_\_

**RELEASE**

The doctor in our clinic specializes in the diagnosis and treatment of functional vision problems. Our clinic does visual efficiency and visual information processing evaluations.

**The doctor in our clinic does not perform primary-care eye health exams.** We do recommend that you have an eye health exam yearly by a primary-care optometrist. If we require you to have this exam prior to your visit with our doctor we will let you know. If you would like a list of primary care optometrists please let us know.

I understand that the doctor will not be assessing my child's eye health in the course of his/her evaluation. I further understand that it is recommended that I have an eye health examination yearly by a primary-care optometrist. I agree to allow Vision Therapy KC to send the records from my exam to my primary care optometrist. If you have not had a primary eye health exam the previous statement is not applicable.

\_\_\_\_\_  
**Signed (patient or parent if patient under 18)**

\_\_\_\_\_  
**Dated**

**DISCLAIMER**

The developmental vision evaluation and report consultation are completed at no charge. No strings attached. We are committed to providing quality developmental vision testing so patients and their families can learn about their possible vision needs, beyond a routine 20/20 eye exam. Providing the testing free of charge removes a significant barrier to those seeking information about this unique and valuable area of vision care.

A summary of the testing, along with diagnosis information and recommendations from the doctor are provided during the consultation for you, the referring doctor and other professionals. We are also glad to provide letters of predetermination for insurance and copies of reports for referring doctors or other professionals.

If records or reports, beyond what is provided during the consultation, are requested by non-returning patients or for use outside of our office, this requires us to charge for both the evaluation and expanded report at our customary fee of \$600.