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Player Name: _____ Age: ____ Sport/Position: _____

School/Team: _____

PATIENT HISTORY Do you or have you ever experienced:

☐ Double Vision	☐ Learning Problems	☐ Glaucoma	☐ Allergies
☐ Sinus Problems	☐ Eye Surgery	☐ High Blood Pressure	☐ Headaches
☐ Diabetes	☐ Retinal Disease	☐ Head Injury	☐ Amblyopia
☐ Color Deficiency	☐ Eye Turn		

Are you currently taking **ANY** medications? ☐ Yes ☐No

If **yes**, please list: _____

CASE HISTORY

1. Have you ever been involved in a visual training program? ☐ Yes ☐No
   If **yes**, when and for what reason(s)? _____
   Do you feel it was successful? ☐ Yes ☐No
2. Do you wear currently glasses or contacts? ☐ Yes ☐No
   If **yes**, how old are they? _____ Are they satisfactory at present? ☐ Yes ☐No
   When are they used? ☐ Near Distance ☐ Far Distance ☐ Both
   Are they used during sports? ☐ Yes ☐No
   If **no**, have you ever worn glasses or contacts in the past? ☐ Yes ☐No
3. Do you ever see blur? ☐ Yes ☐No
   If **yes**, then where? ☐ Near Distance ☐ Far Distance ☐ Both
   How often? _____ Do you see blur while competing? ☐ Yes ☐No
   Describe: _____
4. Do you ever see double? ☐ Yes ☐No
   If **yes**, how often? _____ While competing? ☐ Yes ☐No
   Describe: _____
5. Do you ever feel that you have difficulty “keeping your eye” on a moving object? ☐ Yes ☐No
   If **yes**, please describe some examples: _____
6. Do you notice variations in your performance during a game? ☐ Yes ☐No
   If **yes**, please describe some examples: _____
7. Is performance consistent during critical in-game situations? ☐ Yes ☐No
   If **no**, explain: _____
8. Is your performance the same during night competition as it is for day competition? ☐ Yes ☐No
   If **no**, explain: _____
9. Do you experience loss of concentration during events? ☐ Yes ☐No
   If **yes**, please describe some examples: _____
10. Do you experience any visual difficulties? ☐ Yes ☐No
    If **yes**, please describe some examples: _____