**Therapeutic Lens Follow-Up Form**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Symptoms**: (circle all that apply)

## Are you currently experiencing any of the following? (Please rate severity 0-4, 0 = none, 4 = severe)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Headaches | 0 | 1 | 2 | 3 | 4 |
| Problems Focusing | 0 | 1 | 2 | 3 | 4 |
| Double Vision | 0 | 1 | 2 | 3 | 4 |
| Eye Pain/Strain | 0 | 1 | 2 | 3 | 4 |
| Eye Fatigue | 0 | 1 | 2 | 3 | 4 |
| Words Move on Page | 0 | 1 | 2 | 3 | 4 |
| Motion/Car Sickness | 0 | 1 | 2 | 3 | 4 |
| Movement Sensitivity | 0 | 1 | 2 | 3 | 4 |
| Light Sensitivity | 0 | 1 | 2 | 3 | 4 |
| Nausea | 0 | 1 | 2 | 3 | 4 |
| Clumsiness | 0 | 1 | 2 | 3 | 4 |
| Attention Problems | 0 | 1 | 2 | 3 | 4 |
| Neck Pain/Whiplash | 0 | 1 | 2 | 3 | 4 |
| Disorientation | 0 | 1 | 2 | 3 | 4 |
| Dizziness | 0 | 1 | 2 | 3 | 4 |
| Memory Problems | 0 | 1 | 2 | 3 | 4 |
| Anxiety/Worry | 0 | 1 | 2 | 3 | 4 |
| Depression/Despair | 0 | 1 | 2 | 3 | 4 |
| Anger/Irritability | 0 | 1 | 2 | 3 | 4 |
| Overwhelm/Emotional | 0 | 1 | 2 | 3 | 4 |
| Excitement/Joy | 0 | 1 | 2 | 3 | 4 |

**How long have you been able to wear the therapeutic lenses/perform the therapy since you last saw the doctor?**

Example: 4 weeks

**Were you able to wear the lenses full time? If not, please explain times worn.**

Example: not able to wear while swimming (about 3 hours/day)

**Is there anything else you feel the doctor should know?**

Example: vision started to feel "off" about 1 week ago

**FOLLOW-UP EXAM FORM**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CONCERNS:**

**CURRENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OD \_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OS \_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_ ADD**

**COVER TEST:**

**NEAR DIST**

**\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_ \_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_**

**\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_ \_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_**

**\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_ \_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_**

**OCULAR MOTILITIES:**

**FROM / SMOOTH / RESTRICTION: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**JUMPS: LG / MED / SM / MIDLINE**

**SACCADES: FULL / UNDER / OVERSHOOTING**

**CNP: \_\_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_\_\_**

**BETTER / WORSE WITH ACTIVE R BRAIN**

**BETTER / WORSE WITH ACTIVE L BRAIN**

**STEREO (RANDOT BUTTERFLY):**

**GLOBAL: YES / NO; 6cm-1m / OTHER: \_\_\_\_\_\_\_\_\_\_\_\_**

**ANIMALS: \_\_\_\_\_\_\_\_\_\_\_ CIRCLES: \_\_\_\_\_\_\_\_\_\_\_**

**WORTH 4 DOT: DV \_\_\_\_\_\_\_\_ NV \_\_\_\_\_\_\_\_\_\_\_**

**+2.00 \_\_\_\_\_\_\_\_ -2.00 \_\_\_\_\_\_\_\_\_\_**

**VF: FTHM OD/OS PERIPH AWARENESS: \_\_\_\_\_\_\_\_\_\_\_**

**PUPILS: PERRL -APD**

**7A OD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OD \_\_\_\_\_**

**OS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OS \_\_\_\_\_ OU \_\_\_\_\_**

**ASSESSMENT:**

**CI / AI / SACC / PURS / LACK COORD / OTHER:**

**CONC C LOC / CONC S LOC / STROKE / TOX INJ**

**BLIND FINGER TOUCH:**

**RH LH**

**OD + + + +**

**OS + + + +**

**OU + + + +**

**Z-BELL/BLIND SNAP: DA SILVA**

**High Low Tilt: R / L**

**Diff Turn: R / L**

**+ + + + Diff Arm Up: R / L**

**Diff Hand Reach: R/L**

**Foot Felt Actual**

**+ + + + R I/O/NL I/O/NL**

**L I/O/NL I/O/NL**

**HALLWAY WALK:**

**PULLED: LEFT / CENTER / RIGHT**

**ROTATION: LEFT / CENTER / RIGHT**

**FEET: IN / STRAIGHT / OUT**

**MOBILITY: LOOSE / GOOD / RIGID**

**PLAN:**

**DISP RX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_ ADD PAL / FTBF**

**TINT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RTC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**VT1 / VT2 / VT3 WEEKS: \_\_\_\_\_\_\_\_\_\_ SLP**

**SET: \_\_\_\_\_\_\_\_\_\_\_ FB: \_\_\_\_\_\_\_\_\_**

**LASER PROTOCOL:**

**SYNTONIC PROTOCOL:**

**DR. SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**