Charles Shidlofsky, O.D., P.A.
SVVCS, PA
5934 W. Parker Rd. Ste. 500
Plano, TX 75093
972-312-0177
www.dr-s.net

TBI Questionnaire

Name:_____ **Date of Exam:**_____

Referring Dr.:_____ **Facility:**_____

OT:_____ **PT:**_____ **SLP:**_____

Insurance Co. or Workers Comp: _____

Date of Injury:_____ **Type of Injury:**_____

Pertinent medical history:_____

1. How has your vision changed since your TBI? _____
   _____
2. Are you aware or your left side/right side?_____
3. Do you have dizziness or vertigo?_____
4. Do you have double vision?_____ At distance?_____ At near?_____
5. Do you lean or drift to the right?____ left?____ forward?____
   Backward?____ when?_____ or sitting?_____
6. Do you have difficulty judging depth of stairs or curbs?_____
7. Do you often feel disoriented? _____
8. Do you have an eye turn?_____ a head tilt?_____
   Eye that squints?_____ Droopy eyelid?_____
9. Does print appear to "move" when you read? _____
10. Do you lose your place when reading or tracking? _____
11. Do you have blurry vision? _____

12. Do you get headaches?_____ How often?_____
What part of the head does it affect?_____
Throbbing or dull?_____

13. Do your eyes hurt when you move them?_____

Please use the space below to write any questions or comments that you have:

_____

_____

_____