

# TRI VALLEY OPTOMETRY

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## SPORTS VISION BASELINE CASE HISTORY

ATHLETE NAME \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ LAST EYE EXAM \_\_\_\_\_  
SPORT(S) \_\_\_\_\_ YEARS PLAYED \_\_\_\_\_

### HISTORY

\_\_\_\_ ALLERGIES                      \_\_\_\_ DRUG SENSITIVITIES                      \_\_\_\_ ASTHMA  
\_\_\_\_ HIGH BLOOD PRESSURE                      \_\_\_\_ DIABETES                      \_\_\_\_ HAY FEVER  
\_\_\_\_ SKIN CONDITIONS                      \_\_\_\_ FAINTING                      \_\_\_\_ SURGERY  
\_\_\_\_ HEADACHES (WHEN \_\_\_\_\_ WHERE \_\_\_\_\_)

Have you ever suffered a head injury or had eye surgery?                      Yes / No

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### FAMILY HISTORY

Has anyone in your family had:

\_\_\_\_ DIABETES                      \_\_\_\_ EYE DISEASES                      \_\_\_\_ HEART DISEASE  
\_\_\_\_ TUBERCULOSIS                      \_\_\_\_ HIGH BLOOD PRESSURE                      \_\_\_\_ BLINDNESS

Are you currently taking any medications?                      Yes / No

What medications? \_\_\_\_\_

### SPORTS VISION CASE HISTORY

1. Have you ever been involved in a visual training program?                      Yes / No  
If yes, when and for what reasons? \_\_\_\_\_  
Do you feel that the training program was successful?                      Yes / No  
Explain \_\_\_\_\_
2. Do you wear glasses?                      Yes / No                      How old are your glasses? \_\_\_\_\_  
Are your glasses for                      \_\_\_\_ Distance                      \_\_\_\_ Near                      \_\_\_\_ Both  
Do you use your glasses during sports?                      Yes / No  
If you do not wear glasses, have you ever had glasses in the past?                      Yes / No  
When and why did you stop wearing glasses? \_\_\_\_\_
3. Do you presently wear contact lenses?                      Yes / No  
Type of contact lenses?                      \_\_\_\_ Soft                      \_\_\_\_ Rigid                      \_\_\_\_ Gas Permeable  
Do you wear contact lenses when playing sports?                      Yes / No  
Do you wear contact lenses all day?                      Yes / No  
When did you last update your contact lenses? \_\_\_\_\_  
Do you have any problems with your contact lenses? \_\_\_\_\_  
If you do not wear contact lenses, have you ever worn contact lenses in the past?                      Yes / No  
When and why did you stop wearing contact lenses? \_\_\_\_\_
4. Do you ever have blurred vision?                      Yes / No  
Is your vision blurred at                      \_\_\_\_ Far Distance                      \_\_\_\_ Near Distance  
How often is your vision blurred? \_\_\_\_\_  
Does your vision blur while competing?                      Yes / No  
Explain \_\_\_\_\_

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5. Do you ever have double vision? Yes / No  
Do you see double at \_\_\_\_\_Far Distance \_\_\_\_\_Near Distance  
How often do you see double? \_\_\_\_\_  
Do you see double while competing? Yes / No  
Explain \_\_\_\_\_
6. Do you ever feel you have difficulty "keeping your eye" on a moving object? Yes / No  
Explain \_\_\_\_\_
7. Do you notice variations in your performance during competition? Yes / No  
Explain \_\_\_\_\_
8. Do you notice variations in your performance over time? Yes / No  
Explain \_\_\_\_\_
9. Your performance is most consistent during a sporting event:  
\_\_\_\_\_Early \_\_\_\_\_Later \_\_\_\_\_Equal Throughout
10. Is your performance consistent during critical competition situations? Yes / No
11. Is your performance the same for night competition as for day competition? Yes / No
12. Do you experience loss of concentration during competition? Yes / No  
Explain \_\_\_\_\_
13. Are you experiencing any visual difficulties? Yes / No  
Explain \_\_\_\_\_
14. Please rate your feeling regarding the importance of vision in competition.  
(1=not important, 9=extremely important) 1 2 3 4 5 6 7 8 9  
How do you feel that vision is important in your sport? \_\_\_\_\_
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15. Do you use visualization / imagery techniques? Yes / No  
Explain \_\_\_\_\_

## WHAT ARE THREE GOALS RELATED TO YOUR SPORT THAT YOU WANT TO ACCOMPLISH?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_