INJURY HISTORY

Ocular Trauma Questionnaire

This questionnaire documents the history of your eye injury in your own words: what happened, what you experienced, what care you received, and how your eyes have been since. Be as specific as you can. If you do not remember an exact date, give your best estimate and write "approximately."

NAME *

DATE OF BIRTH *

DATE COMPLETED *

01 THE INJURY EVENT

DATE OF INJURY (OR BEST ESTIMATE) *

LOCATION (BASE, SHIP, DEPLOYMENT SITE, CITY)

WHEN DID THE INJURY OCCUR? *

- ○ During active duty
- ○ During training or drill
- ○ Before service
- ○ After service

WHICH EYE WAS INJURED? *

- ○ Right
- ○ Left
- ○ Both

DESCRIBE WHAT HAPPENED, IN YOUR OWN WORDS *

What were you doing, what struck or entered the eye, and how did the moment unfold? Include who else was present.

HOW WAS THE EYE INJURED? (CHECK ALL THAT APPLY)

- ☐ Blunt impact (fist, ball, tool, airbag, fall)
- ☐ Foreign body (metal, sand, glass, debris)
- ☐ Sharp or penetrating object
- ☐ Vehicle accident
- ☐ Blast or explosion
- ☐ Chemical splash or fumes
- ☐ Welding arc, laser, or intense light
- ☐ Head injury or TBI involving the eye area

IF OTHER OR MORE DETAIL, DESCRIBE MECHANISM

WERE YOU WEARING PROTECTIVE EYEWEAR AT THE TIME?

- ○ Yes
- ○ No
- ○ Do not recall

DID YOU LOSE CONSCIOUSNESS?

- ○ Yes
- ○ No
- ○ Do not recall

02 SYMPTOMS AT THE TIME OF INJURY

IMMEDIATELY AFTER THE INJURY, YOU EXPERIENCED (CHECK ALL THAT APPLY)

- ☐ Eye pain
- ☐ Double vision
- ☐ Bleeding from or inside the eye
- ☐ Tearing or discharge
- ☐ Swelling or bruising around the eye
- ☐ Decreased or lost vision
- ☐ Flashes of light or new floaters
- ☐ Severe light sensitivity
- ☐ Could not open the eye
- ☐ No symptoms at first

DID YOUR VISION RECOVER AFTER THE INJURY?

○ Fully ○ Partially ○ Never recovered ○ Not sure

DESCRIBE YOUR SYMPTOMS IN THE HOURS AND DAYS AFTER THE INJURY

How bad was it, how long did it last, and what did you do about it?

03 MEDICAL CARE AT THE TIME

DID YOU SEEK MEDICAL CARE FOR THE INJURY? *

○ Yes, immediately ○ Yes, within days ○ Yes, weeks or longer after ○ No

WHERE WERE YOU TREATED?

APPROXIMATE DATE(S) OF TREATMENT

WHAT TREATMENT DID YOU RECEIVE?

e.g., irrigation, patching, drops, foreign body removal, stitches, surgery, light duty or profile.

WAS THE INJURY DOCUMENTED IN YOUR SERVICE TREATMENT RECORDS?

○ Yes ○ No ○ Not sure

IF NOT DOCUMENTED OR CARE NOT SOUGHT, EXPLAIN WHY

e.g., field conditions, mission tempo, did not want to leave unit, seemed minor at the time. This matters for your claim.

WITNESSES TO THE INJURY (NAMES AND CONTACT IF KNOWN)

04 COURSE SINCE THE INJURY

SINCE THE INJURY, YOUR EYE SYMPTOMS HAVE BEEN

○ Continuous ○ Off and on ○ Resolved, then returned ○ Resolved

ONGOING OR RECURRING PROBLEMS SINCE THE INJURY (CHECK ALL THAT APPLY)

- ☐ Decreased vision
- ☐ Floaters or flashes
- ☐ Eye pain or headaches
- ☐ Night vision problems
- ☐ Drooping lid or lid scarring
- ☐ Double vision
- ☐ Light sensitivity
- ☐ Dryness or tearing
- ☐ Blind spots or missing side vision
- ☐ Change in the eye's appearance

DIAGNOSES YOU HAVE RECEIVED IN THE INJURED EYE SINCE THE TRAUMA (CHECK ALL THAT APPLY)

- ☐ Traumatic cataract
- ☐ Retinal tear or detachment
- ☐ Iritis or uveitis (inflammation)
- ☐ Orbital (eye socket) fracture
- ☐ Glaucoma or high eye pressure
- ☐ Corneal scar
- ☐ Hyphema (blood in the eye)
- ☐ Optic nerve damage

OTHER DIAGNOSES RELATED TO THE INJURY

EYE SURGERIES OR PROCEDURES SINCE THE INJURY

DATE(S)

HOW HAVE YOUR SYMPTOMS CHANGED OVER THE YEARS?

Describe whether things have stayed the same, worsened, or improved, and roughly when changes happened.

05 CURRENT STATUS

YOUR EYE SYMPTOMS TODAY *

What bothers you now, how often, and which eye is worse.

HOW THE INJURY AFFECTS YOUR DAILY LIFE AND WORK
e.g., driving, reading, job duties, hobbies, glare, depth perception.

CURRENT EYE DOCTOR AND CLINIC

DATE OF MOST RECENT EYE EXAM

RECORDS YOU HAVE OR CAN OBTAIN ABOUT THIS INJURY (CHECK ALL THAT APPLY)

- ☐ Service treatment records mentioning the injury
- ☐ Buddy or lay statements
- ☐ Photographs of the injury
- ☐ Line of duty or incident report
- ☐ Civilian eye care records
- ☐ Awards or personnel records referencing the event

ANYTHING ELSE DR. PEDIGO SHOULD KNOW ABOUT THIS INJURY?

This questionnaire documents the patient-reported history of ocular trauma for medical record purposes and is interpreted alongside service records and clinical examination findings.