

Alderwood

Vision Therapy Center, PLLC

TRANSFORMING LIVES THROUGH VISION

Welcome to our office and thank you for making an appointment for a comprehensive vision examination. On the following pages you will find a Vision Questionnaire and symptom checklist. **Please either return the completed forms to our office before your scheduled appointment, or bring them with you to the examination.**

Thank you again for your cooperation in providing this complete history.
We look forward to seeing you!

16006 Ash Way, Suite 101, Lynnwood, WA 98087
Phone: (425) 787-5200 Fax: (425) 787-5252

Nancy G. Torgerson
Doctor of Optometry

DRIVING DIRECTIONS

Alderwood Vision Therapy Center, PLLC
16006 Ash Way, Suite #101
Lynnwood, WA 98087
(425) 787-5200

Southbound on I-5 coming from Everett, WA

1. Take exit #183, towards 164th St. S.W.
2. Keep RIGHT to stay on Ramp
3. Bear RIGHT (West) onto 164th St SW, then immediately turn RIGHT (North) onto Ash Way
4. Our building will be on your left at 16006 Ash Way #101, Lynnwood, WA 98087

Northbound on I-5 coming from Seattle, WA

1. Take exit #183
2. Turn LEFT (West) onto 164th St SW
3. Turn RIGHT (North) onto Ash Way
4. Our building will be on your left at 16006 Ash Way #101, Lynnwood, WA 98087

Northbound on I-405

1. Merge onto **I-5 North**
2. Take exit #183
3. Turn LEFT (West) onto 164th St SW
4. Turn RIGHT (North) onto Ash Way
5. Our building will be on your left at 16006 Ash Way #101, Lynnwood, WA 98087

From the Edmonds Ferry:

Go on road from ferry until you see I-5 North and take that. Then follow the instructions above for Northbound I-5.

Our office is located in a separate building at the north end of Newberry Square.

ADULT VISION QUESTIONNAIRE

Appointment: Day _____ Date _____ Time _____

Patient's Name: _____

GENERAL INFORMATION

Were you referred to our office? Yes No

If yes, whom may we thank for this referral? _____ Phone: _____

Address _____ Profession: _____

Patient's Full Legal Name: _____ Male Female

Patient's Nickname: _____ Birth Date: _____ Age: _____

Home Address: _____

Home Phone: _____ Work Phone: _____

Social Security Number: _____

Email: _____ Marital status: Single Married Divorced Widowed

What is your occupation? _____ Employer: _____

Business Address: _____

Spouse's Name: _____ Occupation: _____

Spouse's Employer: _____ Phone #: _____

Business Address: _____

In Case of Emergency Contact: _____ Phone: _____

INSURANCE

Do you have Vision Insurance? Yes No If yes, who is the carrier? _____

Insurance Address: _____ Insurance Phone: _____

Subscriber Name: _____ DOB: _____

Subscriber ID# (incl. letter prefix): _____ Group#: _____

Do you have Medical Insurance? Yes No If yes, who is the carrier? _____

Insurance Address: _____ Insurance Phone: _____

Subscriber Name: _____ DOB: _____

Subscriber ID# (incl. letter prefix): _____ Group#: _____

**PLEASE REMEMBER TO BRING YOUR INSURANCE CARD(S)
WITH YOU TO YOUR APPOINTMENT.**

Vision Health History

Reason for today's visit: _____

Last Vision examination: _____ Results: _____

Do you wear glasses? Yes No For: constant wear occasional wear near far

Do you wear contact lenses? Yes* No For: full time wear occasional wear

*** For Your Information: We refer out for contact lens fitting, dispensing and follow-up.**

Type: Soft Rigid Gas Permeable

Visual demands: At work (reading, computer, etc.) _____

At play (sports/hobbies) _____

Medications currently taking: _____

For what condition: _____

General health: Good _____ Poor _____

History of eye surgery/LASIK: Yes or No Explain: _____

Allergies: Yes No Specify: _____

Social History:

Do you smoke? Yes No What do you smoke? _____ How many per day? _____

Do you drink? Yes No What do you drink? _____ How much per day? _____

Do you use recreational drugs? Yes No What Drug? _____ How often: _____

List patient's special needs (autism/developmental delays, etc): _____

Do you have a seizure disorder? Yes No

Do you have a sleep disorder? Yes No

List any special concerns: _____

Have you or a family member been treated for any condition related to:

	<u>Patient</u>	<u>Family</u>	<u>Who</u>		<u>Patient</u>	<u>Family</u>	<u>Who</u>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears, Nose, Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____	Endocrine Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular health	<input type="checkbox"/>	<input type="checkbox"/>	_____	Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	_____	Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal health	<input type="checkbox"/>	<input type="checkbox"/>	_____	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hematological/lymphatic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic/immunologic	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other: _____			

Specifically is there any family history of:

	<u>Patient</u>	<u>Family</u>	<u>Who</u>		<u>Patient</u>	<u>Family</u>	<u>Who</u>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Amblyopia(lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Learning problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____	Retinal disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	_____	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double-vision	<input type="checkbox"/>	<input type="checkbox"/>	_____	Retinitis Pigmentosa	<input type="checkbox"/>	<input type="checkbox"/>	_____
Strabismus(eye turn)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING:

Yes

- | | |
|--|--------------------------|
| Eyes ache | <input type="checkbox"/> |
| Eyes pull or tug | <input type="checkbox"/> |
| Difficulty moving or turning eyes | <input type="checkbox"/> |
| Pain with movement of eyes | <input type="checkbox"/> |
| Eyes twitch | <input type="checkbox"/> |
| Pain in or around eyes | <input type="checkbox"/> |
| Eye redness | <input type="checkbox"/> |
| Burning eyes | <input type="checkbox"/> |
| Watery eyes | <input type="checkbox"/> |
| Itchy eyes | <input type="checkbox"/> |
| Dry eyes | <input type="checkbox"/> |
| Brightness is bothersome | <input type="checkbox"/> |
| Motion sickness / car sickness | <input type="checkbox"/> |
| Headaches | <input type="checkbox"/> |
| Blurred vision at distance | <input type="checkbox"/> |
| Blurred vision at near | <input type="checkbox"/> |
| Tunnel vision / Loss of visual field | <input type="checkbox"/> |
| Flashes of light | <input type="checkbox"/> |
| Dizziness | <input type="checkbox"/> |
| Double vision | <input type="checkbox"/> |
| Frequent Sties | <input type="checkbox"/> |
| | |
| Head moves when reading | <input type="checkbox"/> |
| Lose place often when reading | <input type="checkbox"/> |
| Avoid reading or writing | <input type="checkbox"/> |
| Words jump or move around when reading | <input type="checkbox"/> |
| Short attention span for reading or writing | <input type="checkbox"/> |
| Skip words frequently when reading | <input type="checkbox"/> |
| One eye turns in, out, up or down | <input type="checkbox"/> |
| Movement of objects in the environment is bothersome | <input type="checkbox"/> |
| Fluorescent light is bothersome | <input type="checkbox"/> |
| Patterned wallpaper or carpets are bothersome | <input type="checkbox"/> |
| Objects jump in and out of field of view | <input type="checkbox"/> |
| Reduced depth perception | <input type="checkbox"/> |
| Loss of interest/concentration when doing close work | <input type="checkbox"/> |
| Orient writing/drawing poorly on page | <input type="checkbox"/> |
| Squinting, covering or closing one eye | <input type="checkbox"/> |
| Head tilts during desk work | <input type="checkbox"/> |
| Comprehension decreases the longer you read | <input type="checkbox"/> |
| Feels sleepy with reading | <input type="checkbox"/> |
| Rubs eyes frequently after/while reading/on computer | <input type="checkbox"/> |
| Trouble with spelling | <input type="checkbox"/> |
| Often have to re-read a line just read | <input type="checkbox"/> |
| Difficulty remembering what is read | <input type="checkbox"/> |
| Turns head a great deal with reading or on computer | <input type="checkbox"/> |

Date: _____ Dr's Initials: _____

- Close or cover an eye (right or left)
- Often reverses letters, words, or numbers
- Dislike tasks requiring sustained visual attention
- Feel nervous, irritable, restless, or frustrated after sustained visual concentration
- Lose awareness of surroundings when concentrating
- Blink a lot
- Difficulty using binoculars

- Hold books too close
- Difficulty changing focus far to near
- Discomfort when reading
- Eyes tire quickly when reading, sewing, or on computer
- Distance blurs when looking up from close work
- Vision blurs when concentrating

- Restless when doing desk work
- Eye/body coordination activities (ie dancing) are difficult
- Tailgate when driving
- Eye/hand coordination sports (ie. tennis, baseball) are difficult
- Trouble judging distance when parking/pulling into traffic
- Frequently trip or stumble
- Feel uncomfortable in crowded area with a lot of movement

Print Name: _____

Signature: _____