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.

16006 Ash Way, #101, Lynnwood, WA 98087 (425) 787-5200

ADULT STRABISMUS 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 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 (autistim/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:

	Patient	Family	Who		Patient	Family	Who
Eyes	☐	☐	_____	Neurological	☐	☐	_____
Ears, Nose, Throat	☐	☐	_____	Endocrine Disorder	☐	☐	_____
Cardiovascular health	☐	☐	_____	Genitourinary	☐	☐	_____
Respiratory	☐	☐	_____	Skin	☐	☐	_____
Gastrointestinal health	☐	☐	_____	Musculoskeletal	☐	☐	_____
Psychiatric	☐	☐	_____	Hematological/lymphatic	☐	☐	_____
Allergic/immunologic	☐	☐	_____	Other: ________________________________			

Specifically is there any family history of:

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

Date: ________ Dr's Initials:______

STRABISMUS HISTORY

At what age was it first noticed or suspected that was an eye turning? ____________________

Did the eye begin turning suddenly or gradually? ____________________

Does the eye turn in ☐, out ☐, up ☐, or down ☐? (check all that apply)

Is the eye turn getting worse ☐ or better ☐ or is there no change ☐

Is it always the same eye that turns? Yes ☐ No ☐ If yes, which eye? Right ☐ Left ☐

Is the eye turn always present? Yes ☐ No ☐

If no, under what conditions is it present? ____________________

Does the eye always turn the same amount? Yes ☐ No ☐

If no, explain: ____________________

Do you notice if the eye turns more when you look:

up close?	Yes ☐	No ☐
in the distance?	Yes ☐	No ☐
to your left?	Yes ☐	No ☐
to your right?	Yes ☐	No ☐
up?	Yes ☐	No ☐
down?	Yes ☐	No ☐

Does one pupil ever appear to be larger than the other? Yes ☐ No ☐

Do you ever notice one or both eyes shaking rapidly? Yes ☐ No ☐

PREVIOUS TREATMENTS

Have you had a previous visual evaluation? Yes ☐ No ☐

If yes, Doctor's Name: ____________________ Date of last evaluation: __________

Results and recommendations: ____________________

Were glasses, contact lenses, or other optical devices recommended or prescribed? Yes___ No____

If yes, bifocal? ☐ single vision? ☐ contact lenses? ☐ Other? ☐ Explain: ____________________

Are they worn? Yes ☐ No ☐

If yes, when? ____________________

If no, why not? ____________________

Does the eye turn less when the prescription is worn? Yes ☐ No ☐ Unsure ☐

Have you been told that you have amblyopia (lazy eye)? Yes ☐ No ☐

Has there been any treatment using an eye patch? Yes ☐ No ☐

If yes, please describe when the patching was started, how the patching was done, including the age it started, the eye patched, the duration of treatment, and an estimate of the results: ________

____

____

Has there been any surgical treatment? Yes ☐ No ☐

If yes, please describe the surgery, including the age surgery was performed, the number of operations, the eye(s) operated on, and an estimate of the cosmetic and subjective results: ______

____

____

Was the surgeon satisfied with the results of surgery? Yes ☐ No ☐ Explain: ____________________

____

Were you satisfied with the results of surgery? Yes ☐ No ☐ Explain: ____________________

____

Have surgical results been maintained? Yes ☐ No ☐ Explain: ____________________

____

Has there been any visual therapy? Yes ☐ No ☐

If yes, Doctor's name: ____________________

Date: ________ Dr's Initials:______

Please describe the type of visual therapy, including duration, the age at which it started and an estimate of results: ____

____

Are you here for a second opinion regarding surgery or other treatment? Yes ☐ No ☐

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING:

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

Date: ________ Dr's Initials:______

Symptom	
Trouble with spelling	☐
Often have to re-read a line just read	☐
Difficulty remembering what is read	☐
Turns head a great deal with reading or on computer	☐
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	☐

Symptom	
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	☐

Symptom	
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: ____

Date: _________ Dr's Initials:______

Date: _________ Dr’s Initials:_______