ALDERWOOD VISION THERAPY CENTER, PLLC Drs. Torgerson, Murphy, Maher, Hash, & Schiller
16006 Ash Way, #101, Lynnwood, WA 98087 (425) 787-5200

Dr. Initials/Date: _____ /_____

INITIAL VISION QUESTIONNAIRE FOR ADULTS

Appointment Date: ____ /____ /____

Full Legal Name: _____ Date of Birth: ____ /____ /____ Age: _____
Name you prefer to go by: _____

GENERAL INFORMATION
Were you referred to our office? Yes ☐ No ☐
By whom? _____ His/Her profession: _____
Referral address: _____ Referral Phone#: _____
May we update the referral source? Yes ☐ No ☐

Your Occupation_____ Employer _____

Spouse's Name_____ Birth Date _____
Spouse's Occupation_____ Phone _____
Children's names and birth dates _____

PRESENT SITUATION
Why do you need a visual evaluation?_____

_____

Do you have any special concerns regarding your vision? _____

_____

VISUAL HISTORY
Has your vision been previously evaluated? Yes ☐ No ☐
If yes, Doctor's Name: _____ Date of last evaluation: _____ /_____ /_____
Reason for examination: _____
Results and recommendations: _____

Do you wear glasses, contact lenses, and/or use a special optical device? Yes ☐ No ☐
If yes, what? _____
Do you wear them? Yes ☐ No ☐ If yes, when? _____
If no, why? _____

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

Have you had any type of eye surgery? Yes ☐ No ☐
By Whom: _____For what: _____

Members of the family who have/had visual conditions:

Name	Age	Visual Situation
_____	____	_____
_____	____	_____
_____	____	_____

MEDICAL HISTORY

Primary Care Doctor's Name: _____

May we update your primary care doctor? Yes ☐ No ☐

Your current state of health: _____

List illnesses, conditions etc.:

Age	Severe	Mild	Complications

Are you generally healthy? Yes ☐ No ☐

If no, explain: _____

Do you have any chronic problems? Yes ☐ No ☐

If yes, please list: _____

Have you had an acquired brain injury and/or concussion? Yes ☐ No ☐

If yes, please explain: _____

Have you had a neurological evaluation? Yes ☐ No ☐

By whom? _____ Results and recommendations: _____

Do you use a mobility aid? Yes ☐ No ☐

If yes, what aid? (Circle) Wheelchair Walker Other:_____

NUTRITIONAL INFORMATION

Current Diet: Excellent ☐ Good ☐ Fair ☐ Poor ☐

Explain: _____

TELEVISION VIEWING/LEISURE TIME ACTIVITIES

Visual demands at work (reading, computer, etc.) _____

Visual demands at play (sports/hobbies) _____

Do you read for pleasure? Yes ☐ No ☐

Do you spend time using computer? Yes ☐ No ☐

If yes, How often? _____ Viewing distance? _____

Do you spend time using small screen devices (ie. smart phones, tablets) Yes ☐ No ☐

If yes, how much? _____ How often? _____

Today's Date: ___ /___ /___

Print Name: _____

Signature: _____