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

FAMILY AND SOCIAL HISTORY

Today's Date: _____/______/______
Name: ____________________________ Date of Birth: ______/_______/_______ Age: _______

Health History Update

Since your last visit, have you had any NEW visual or medical problems, new surgeries or hospitalizations? (Include year)

☐ None

____
____
____
____

Medications currently taking and for what condition:

☐ None

____
____
____
____

Allergies:

☐ None

____
____
____
____

Social History

Marital Status:
☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Widowed

Language: ______________________________

Education Completed:
☐ Grade ☐ H.S. ☐ College ☐ Adv. Degree
☐ Other ______________________________

Employment Status:
☐ Working Occupation:______________
☐ Unemployed ☐ Retired ☐ Disabled

Patient and Family History

List **you** and/or family member and age diagnosed

Alcoholism ______________________________
Amblyopia ______________________________
Asthma ______________________________
Cancer ______________________________
Color Deficiency______________________________
Diabetes ______________________________
Double Vision______________________________
Glaucoma______________________________
Headaches/Migraines______________________________
Heart Disease______________________________
High Blood Pressure______________________________
High Cholesterol______________________________
Learning Problems______________________________
Macular Degeneration ______________________________
Mental Illness (specify) ______________________________
Multiple Sclerosis ______________________________
Osteoporosis ______________________________
Retinal disease______________________________
Retinitis Pigmentosa______________________________
Strabismus (eye turn) ______________________________
Stroke______________________________
Tuberculosis______________________________
Thyroid Condition______________________________

Risk Factors

Tobacco: ☐ Never
Year Started: _______ Year Quit: _______
☐ Cigarettes: ___ #/day ☐ Cigars: ___ #/week
☐ Chew: ___ cans/day ☐ Pipe
☐ Passive Smoke Exposure ☐ Current ☐ Past

Alcohol: ☐ Yes ☐ No
Type: _______________ drinks ______/day

Caffeine: ☐ Yes ☐ No drinks ______/day

Exercise Type: _______________ times ___/week

Recreational Drugs: ☐ Yes ☐ No Type: ______

PATIENT OR PARENT/GUARDIAN SIGNATURE: ______________________________

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REVIEW OF SYSTEMS

Today's Date: _____/______/______

Name: ____________________________ Date of Birth: ______/_______/________ Age: ________

Problems you had in the past/are currently experiencing: ☐ None

General	Past	Present
Weight loss/gain	☐	☐
Fatigue	☐	☐
Fever or chills	☐	☐
Weakness	☐	☐
Trouble sleeping	☐	☐

Head	Past	Present
Headache	☐	☐
Head Injury	☐	☐
Concussion	☐	☐
Neck pain	☐	☐

Eyes	Past	Present
Vision loss/changes	☐	☐
Pain	☐	☐
Redness	☐	☐
Blurry vision	☐	☐
Double vision	☐	☐
Flashing lights	☐	☐
Specks	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐

Throat, Mouth, Nose, & Ears	Past	Present
Bleeding	☐	☐
Sore tongue	☐	☐
Dry mouth	☐	☐
Sore throat	☐	☐
Hoarseness	☐	☐
Sinus pain	☐	☐
Decreased hearing	☐	☐
Ringing in ears	☐	☐

Respiratory	Past	Present
Cough	☐	☐
Sputum	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐

Cardiovascular	Past	Present
Chest pain/discomfort	☐	☐
Tightness	☐	☐
Palpitations	☐	☐
Shortness of breath with activity	☐	☐

Gastrointestinal	Past	Present
Swallowing difficulties	☐	☐
Heartburn	☐	☐
Change in appetite	☐	☐
Nausea/vomiting	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐

Musculoskeletal	Past	Present
Muscle or joint pain	☐	☐
Muscle weakness	☐	☐
Trauma	☐	☐

Neurological	Past	Present
Present	☐	☐
Dizziness	☐	☐
Fainting	☐	☐
Seizures	☐	☐
Weakness	☐	☐
Numbness	☐	☐
Tremor	☐	☐

Mental Health	Past	Present
Nervousness	☐	☐
Stress	☐	☐
Depression	☐	☐
Memory loss	☐	☐
Anxiety	☐	☐

Allergy	Past	Present
Persistent infections	☐	☐
Hives	☐	☐
Seasonal Allergies	☐	☐

PATIENT OR PARENT/GUARDIAN SIGNATURE: ______________________________________

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