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

# FAMILY AND SOCIAL HISTORY

Account:_____

Today's Date: _____/_____/_____

Name: _____ Date of Birth: _____/_____/_____ Age: _____

**Answer all questions about the <u>patient being seen today</u>.**

**Patient Health History Update**
Since last visit with Alderwood Vision Therapy, list any NEW visual or medical problems, new surgeries or hospitalizations (Include year)
If this is your first visit, please list all.

_____
_____
_____
_____

Medications patient is currently taking and for what condition:

_____
_____
_____
_____

Patient Allergies:

_____
_____
_____
_____

**Patient Social History**
Patient Marital Status:
☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Widowed

Language: _____

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

Patient Employment Status:
☐ Working Occupation:_____
☐ Unemployed ☐ Retired ☐ Disabled

**Patient and Family History**
List either **the patient** and/or other family members 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_____

**Patient 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 (the patient) had in the past/are currently experiencing:**

| **General** | Past | Present | Never |
|---|---|---|---|
| Weight loss/gain | ☐ | ☐ | ☐ |
| Fatigue | ☐ | ☐ | ☐ |
| Fever or chills | ☐ | ☐ | ☐ |
| Weakness | ☐ | ☐ | ☐ |
| Trouble sleeping | ☐ | ☐ | ☐ |

| **Head** | Past | Present | Never |
|---|---|---|---|
| Headache | ☐ | ☐ | ☐ |
| Head Injury | ☐ | ☐ | ☐ |
| Concussion | ☐ | ☐ | ☐ |
| Neck pain | ☐ | ☐ | ☐ |

| **Eyes** | Past | Present | Never |
|---|---|---|---|
| Vision loss/changes | ☐ | ☐ | ☐ |
| Pain | ☐ | ☐ | ☐ |
| Redness | ☐ | ☐ | ☐ |
| Blurry vision | ☐ | ☐ | ☐ |
| Double vision | ☐ | ☐ | ☐ |
| Flashing lights | ☐ | ☐ | ☐ |
| Specks | ☐ | ☐ | ☐ |
| Glaucoma | ☐ | ☐ | ☐ |
| Cataracts | ☐ | ☐ | ☐ |

| **Throat, Mouth, Nose, & Ears** | Past | Present | Never |
|---|---|---|---|
| Bleeding | ☐ | ☐ | ☐ |
| Sore tongue | ☐ | ☐ | ☐ |
| Dry mouth | ☐ | ☐ | ☐ |
| Sore throat | ☐ | ☐ | ☐ |
| Hoarseness | ☐ | ☐ | ☐ |
| Sinus pain | ☐ | ☐ | ☐ |
| Decreased hearing | ☐ | ☐ | ☐ |
| Ringing in ears | ☐ | ☐ | ☐ |

| **Respiratory** | Past | Present | Never |
|---|---|---|---|
| Cough | ☐ | ☐ | ☐ |
| Sputum | ☐ | ☐ | ☐ |
| Shortness of breath | ☐ | ☐ | ☐ |
| Wheezing | ☐ | ☐ | ☐ |

| **Cardiovascular** | Past | Present | Never |
|---|---|---|---|
| Chest pain/discomfort | ☐ | ☐ | ☐ |
| Tightness | ☐ | ☐ | ☐ |
| Palpitations | ☐ | ☐ | ☐ |
| Shortness of breath with activity | ☐ | ☐ | ☐ |

| **Gastrointestinal** | Past | Present | Never |
|---|---|---|---|
| Swallowing difficulties | ☐ | ☐ | ☐ |
| Heartburn | ☐ | ☐ | ☐ |
| Change in appetite | ☐ | ☐ | ☐ |
| Nausea/vomiting | ☐ | ☐ | ☐ |
| Constipation | ☐ | ☐ | ☐ |
| Diarrhea | ☐ | ☐ | ☐ |

| **Musculoskeletal** | Past | Present | Never |
|---|---|---|---|
| Muscle or joint pain | ☐ | ☐ | ☐ |
| Muscle weakness | ☐ | ☐ | ☐ |
| Trauma | ☐ | ☐ | ☐ |

| **Neurological** | Past | Present | Never |
|---|---|---|---|
| Dizziness | ☐ | ☐ | ☐ |
| Fainting | ☐ | ☐ | ☐ |
| Seizures | ☐ | ☐ | ☐ |
| Weakness | ☐ | ☐ | ☐ |
| Numbness | ☐ | ☐ | ☐ |
| Tremor | ☐ | ☐ | ☐ |

| **Mental Health** | Past | Present | Never |
|---|---|---|---|
| Nervousness | ☐ | ☐ | ☐ |
| Stress | ☐ | ☐ | ☐ |
| Depression | ☐ | ☐ | ☐ |
| Memory loss | ☐ | ☐ | ☐ |
| Anxiety | ☐ | ☐ | ☐ |

| **Allergy** | Past | Present | Never |
|---|---|---|---|
| Persistent infections | ☐ | ☐ | ☐ |
| Hives | ☐ | ☐ | ☐ |
| Seasonal Allergies | ☐ | ☐ | ☐ |

**PATIENT OR PARENT/GUARDIAN SIGNATURE:** _____

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