

ALDERWOOD VISION THERAPY CENTER, PLLC

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:

<u>Name</u>	<u>Age</u>	<u>Visual Situation</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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.:

<u>Age</u>	<u>Severe</u>	<u>Mild</u>	<u>Complications</u>

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: _____