ALDERWOOD VISION THERAPY CENTER, PLLC
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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