WELCOME TO ENVISION EYECARE.

We appreciate you choosing us for your professional eye care.

Ms., Miss Mr., Mrs. (last)__________________ (first)_____________ (mi)_____ Today's Date_____________
Nickname___________________________________ Single____ Married____ Widowed____Divorced______
Home Address:____ Date of Birth:_____/______/________
City:________________________ ST:_________ Zip: __________ Home Phone: (_____)__________________
Preferred Phone Number: (______)____________________**Email:** ___________________________________
Have we taken care of your family members:❑ Yes Whom?_______________________________________
Medical Insurance:___________________________ Vision Insurance:_______________________________

What is the Reason(s) for your Visit? ____

Are you having vision problems without glasses? ❑Yes, distance ❑Yes, computer ❑Yes, near ❑ No
Glasses Do you wear glasses? ❑ Yes ❑ No **(If no, skip to next section)**
Are you having vision problems with glasses? ❑Yes, distance ❑Yes, computer ❑Yes, near ❑ No
Are you interested in getting new glasses? ❑ Yes ❑ If my prescription changes ❑ No
Do your glasses have an anti-glare lenses? ❑ Yes ❑ No Do you have prescription sunglasses? ❑ Yes ❑ No

Contact Lenses Do you wear contact lenses? ❑ Yes ❑ No Do you want to try them today? ❑ Yes ❑ No
Are you interested in colored contacts? ❑Yes **Refractive Surgery** Are you interested in laser surgery? ❑Yes

Ocular History ❑Cataracts ❑Macular Degeneration ❑Glaucoma ❑Dry Eye / Burning /Pain ❑Infection ❑Allergies
❑Lazy Eye/ Eye Turn ❑Floaters ❑Flashes ❑Retinal Detachment ❑Redness ❑Itching ❑Light Sensitivity ❑Eyestrain
❑Watery Eyes / Discharge ❑Poor Night Vision /Glare ❑Double Vision ❑Surgery ❑Injury ❑Droopy eyelid ❑Other

Activities: Employer:___________________________Occupation:__________________________________
Computer hours / day?_________ Hobbies? ____

Name of Medical Doctor:____ Last Medical Exam: ___________
Medications: ❑ No Medications ❑ No changes ❑ Will Provide List__________________________________
____
Allergies ❑ No known allergies ____

Any changes to your Medical History since last visit? ❑ Yes ❑ No. If yes, please complete below.

Review of Systems - **Please circle all that apply or fill-in the blank for those not listed.**

CONSTITUTIONAL: Developmental disabilities / Fatigue / Cancer, Type________________/ ____________________
EARS, NOSE, THROAT: Hearing loss / Sinusitis / Dry mouth / Laryngitis / _______________________________
NEUROLOGICAL: Multiple sclerosis / Epilepsy / Cerebral Palsy / Tumor / Migraine / Headaches _______________
PSYCHIATRIC: Depression / ADHD / Anxiety / Bipolar / ____
CARDIOVASCULAR: High blood pressure / Stroke / Heart disease_____________________________________
RESPIRATORY: Asthma / Bronchitis / Emphysema / Chronic obstruction / Sleep Apnea /_______________________
GASTROINTESTINAL: Crohn's / Colitis / Ulcer / Acid reflux / Celiac disease / ___________________________
GENITOURINARY: Kidney disease / Prostate disease / Herpes / Chlamydia / _______________________________
MUSCULOSKELETAL: Arthritis / Fibromyalgia / Ankylosing Spondylitis /Gout / ______________ _______________
INTEGUMENTARY: Eczema / Rosacea / Psoriasis / Cold Sores / Shingles / ________________________________
ENDOCRINE: Type 2 Diabetes / Type 1 Diabetes / Hypothyroid / Hyperthryoid – Grave's Disease / _________________
HEMOTOLOGIC / LYMPHATIC: Anemia / Blood Loss / Ulcer / High Cholesterol / ___________________________
ALLERGIC / IMMUNOLOGIC: Rheumatoid Arthritis / Lupus / Sjogren's / HIV / Gonorrhea / Hepatitis / Syphilis / ____
Are you pregnant? ❑ Yes ❑ No ❑ Maybe Are you nursing? ❑ Yes ❑ No