WELCOME TO ENVISION EYECARE.

We appreciate you choosing us for your professional eye care.

Child's Name (last)____________________ (first)__________________ (mi)_____ Today's Date________________
Nickname______________________________Home Address: ____
City:____________________________ ST:_________ Zip: ____________ Date of Birth: _____/______/________
Preferred Phone: (______)______________**Email:** ____
Have we taken care of your family members:❑ Yes Whom?____
Medical Insurance:_____________________________ Vision Insurance:___________________________________

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

Is your child having vision problems without glasses? ❑Yes, distance ❑Yes, computer ❑Yes, near ❑ No
Glasses Does your child wear glasses? ❑ Yes ❑ No **(If no, skip to next section)**
Is your child having vision problems with glasses? ❑Yes, distance ❑Yes, computer ❑Yes, near ❑ No
Is your child interested in getting new glasses? ❑ Yes ❑ If the prescription changes ❑ No
Do they have an anti-glare? ❑ Yes ❑ No Do they have prescription sunglasses or changing tint? ❑ Yes ❑ No
Contact Lenses Does your child wear contact lenses?❑ Yes ❑ No Do they want to try them? ❑ Yes ❑ No

Ocular History ❑Cataracts ❑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

Hobbies and Activities:
Child's current grade in school ________________ Does your child know numbers and letters? ❑ Yes ❑ No
How many hours per day on the computer? __________ How many hours per week spent outdoors? ___________
What hobbies does your child enjoy? ❑ Reading ❑ Video Games ❑ Sports_________________________________
❑ Other ____ Do these activities strain your child's eyes? ❑ Yes ❑ No

Name of Medical Doctor:____ Last Medical Exam: ___________
Medications*:* ❑ No Medications ❑ No changes ❑ Provided List ______________________________________
____
Allergies ❑ No known allergies____

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

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 / ____