



**Welcome to Envision Eyecare. We are delighted you are here today!**

Name \_\_\_\_\_ M/F Today's Date \_\_\_/\_\_\_/\_\_\_  
 Address \_\_\_\_\_ Apt \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_  
 City/State \_\_\_\_\_ Zip \_\_\_\_\_ Age \_\_\_\_\_

**Insurance Information**

Social Security # \_\_\_\_\_ Home (\_\_\_\_)\_\_\_\_-\_\_\_\_\_  
 Medical Insurance Company \_\_\_\_\_ Work (\_\_\_\_)\_\_\_\_-\_\_\_\_\_  
 Vision Insurance Company \_\_\_\_\_ Cell (\_\_\_\_)\_\_\_\_-\_\_\_\_\_  
 Email \_\_\_\_\_

Date of Last Eye Exam \_\_\_\_\_ Doctor's Name \_\_\_\_\_  
 Date of Last Medical Exam \_\_\_\_\_ Doctor's Name \_\_\_\_\_

Reason for Today's visit \_\_\_\_\_

**Please check Yes or No (If applies to a family member, use the appropriate initial: F-Father, M-Mother, B-Brother, S-Sister, G-Grandparent, C-Child)**

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| <p><b>Eyes</b><br/> <b>Y N</b><br/> <input type="checkbox"/> <input type="checkbox"/> Sudden Loss of Vision<br/> <input type="checkbox"/> <input type="checkbox"/> Lazy Eye—R/L (please circle)<br/> <input type="checkbox"/> <input type="checkbox"/> Double vision<br/> <input type="checkbox"/> <input type="checkbox"/> Macular Degeneration<br/> <input type="checkbox"/> <input type="checkbox"/> Cataracts<br/> <input type="checkbox"/> <input type="checkbox"/> Glaucoma<br/> <input type="checkbox"/> <input type="checkbox"/> Dry/Sandy/Gritty Feeling<br/> <input type="checkbox"/> <input type="checkbox"/> Itching/ Redness<br/> <input type="checkbox"/> <input type="checkbox"/> Discharge/Tearing/Watering<br/> <input type="checkbox"/> <input type="checkbox"/> Retinal Detachment<br/> <input type="checkbox"/> <input type="checkbox"/> Glare/Light Sensitivity<br/> <input type="checkbox"/> <input type="checkbox"/> Flashes/Floaters<br/> <input type="checkbox"/> <input type="checkbox"/> Eye Surgery<br/> <input type="checkbox"/> <input type="checkbox"/> Eye Injury</p> <p><b>Cardiovascular</b><br/> <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure<br/> <input type="checkbox"/> <input type="checkbox"/> Heart Disease</p> | <p><b>Constitutional</b><br/> <b>Y N</b><br/> <input type="checkbox"/> <input type="checkbox"/> Fever, Weight loss/Gain<br/> <input type="checkbox"/> <input type="checkbox"/> Fatigue</p> <p><b>Endocrine</b><br/> <input type="checkbox"/> <input type="checkbox"/> Diabetes-# of yrs _____<br/> <input type="checkbox"/> <input type="checkbox"/> Thyroid/Thyroid Eye Disease<br/> <input type="checkbox"/> <input type="checkbox"/> Gout<br/> <input type="checkbox"/> <input type="checkbox"/> High Cholesterol</p> <p><b>Gastrointestinal</b><br/> <input type="checkbox"/> <input type="checkbox"/> Ulcer<br/> <input type="checkbox"/> <input type="checkbox"/> Acid Reflux Syndrome<br/> <input type="checkbox"/> <input type="checkbox"/> Irritable Bowel Syndrome</p> <p><b>Genitourinary</b><br/> <input type="checkbox"/> <input type="checkbox"/> Urinary/Bladder disorder<br/> <input type="checkbox"/> <input type="checkbox"/> STD</p> <p><b>Head</b><br/> <input type="checkbox"/> <input type="checkbox"/> Sinus Congestion<br/> <input type="checkbox"/> <input type="checkbox"/> Runny Nose/Post Nasal Drip<br/> <input type="checkbox"/> <input type="checkbox"/> Dry Throat/Mouth</p> | <p><b>Immunologic</b><br/> <input type="checkbox"/> <input type="checkbox"/> Autoimmune disease<br/> <input type="checkbox"/> <input type="checkbox"/> AIDs/HIV</p> <p><b>Integumentary</b><br/> <input type="checkbox"/> <input type="checkbox"/> Skin Irritations</p> <p><b>Musculoskeletal</b><br/> <input type="checkbox"/> <input type="checkbox"/> Arthritis-Osteo/Rheumatoid<br/> <input type="checkbox"/> <input type="checkbox"/> Skeletal disorder</p> <p><b>Neurological</b><br/> <input type="checkbox"/> <input type="checkbox"/> Headache/Migraine<br/> <input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis</p> <p><b>Psychiatric</b><br/> <input type="checkbox"/> <input type="checkbox"/></p> <p><b>Respiratory</b><br/> <input type="checkbox"/> <input type="checkbox"/> Asthma<br/> <input type="checkbox"/> <input type="checkbox"/> Chronic Bronchitis/Cough</p> <p><b>Pregnant</b><br/> <input type="checkbox"/> <input type="checkbox"/></p> <p><b>Other</b><br/> <input type="checkbox"/> <input type="checkbox"/></p> <p><b>Tobacco Use?</b> _____</p> |
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**List current Medications—Rx and OTC** \_\_\_\_\_

**List Allergies (Environmental and Medications)** \_\_\_\_\_

**Glasses:** Age of current pair \_\_\_\_\_ Concerns? \_\_\_\_\_  
 Do you use sunglasses? Y or N. Concerns? \_\_\_\_\_

**Contact Lenses:** RGP lens use or Soft Disposable Contacts? (Please circle) Concerns? \_\_\_\_\_  
 If Disposable, how often do you replace the lenses? \_\_\_\_\_ Do you sleep in the contacts? Y or N

**Who should we thank for referring you?** \_\_\_\_\_