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Welcome to Envision Eyecare

Name_____Today's Date:___ / ___ /___

Birth Date: _____ / _____ / _____ Last Eye Exam: _____ / _____ / _____

Name of Medical Doctor: _____Last Medical Exam _____ / ____ / _____

Ocular History Have you ever been diagnosed with any of the following conditions?

Cataract	❑No	❑Yes	Dry Eye	❑No	❑Yes
Age-related Macular Degeneration	❑No	❑Yes	Eye infection/inflammation/allergy	❑No	❑Yes
Glaucoma	❑No	❑Yes	Floaters/Flashes in Vision	❑No	❑Yes
Diabetes	❑No	❑Yes	Iritis/Uveitis	❑No	❑Yes
Diabetic Retinopathy	❑No	❑Yes	Retinal degenerations	❑No	❑Yes

Are you experiencing any of the following eye concerns?

Redness	❑No	❑Yes
Burning	❑No	❑Yes
Itching	❑No	❑Yes
Tearing	❑No	❑Yes
Discharge	❑No	❑Yes

Other_____

Are you having any of the following vision concerns?

Blurred vision	❑No	❑Yes	Poor night vision	❑No	❑Yes
Eyestrain	❑No	❑Yes	Bothersome night glare	❑No	❑Yes
Eye pain	❑No	❑Yes	Double vision	❑No	❑Yes
Severe sensitivity to lights	❑No	❑Yes	Total loss of vision	❑No	❑Yes
Headaches	❑No	❑Yes			

Family History

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions:

DISEASE/CONDITION			**RELATIONSHIP TO YOU**
Blindness	❑No	❑Yes	_____
Crossed Eyes	❑No	❑Yes	_____
Glaucoma	❑No	❑Yes	_____
Macular Degeneration	❑No	❑Yes	_____
Retinal Detachment/Disease	❑No	❑Yes	_____
Diabetes	❑No	❑Yes	_____
Cancer	❑No	❑Yes	_____
High Blood Pressure	❑No	❑Yes	_____

REVIEW OF SYSTEMS Do you currently or have you ever had any problems in the following areas?

CONSTITUTIONAL

Fatigue	❑No	❑Yes
Cancer	❑No	❑Yes

EARS, NOSE, THROAT

Hearing Loss	❑No	❑Yes
Sinusitis	❑No	❑Yes
Dry mouth	❑No	❑Yes
Laryngitis	❑No	❑Yes

NEUROLOGICAL

MS	❑No	❑Yes
Epilepsy	❑No	❑Yes
Cerebral Palsy	❑No	❑Yes
Tumor	❑No	❑Yes
Stroke	❑No	❑Yes
Migraines	❑No	❑Yes

PSYCHIATRIC

Depression	❑No	❑Yes
ADHD	❑No	❑Yes
Anxiety Disorder	❑No	❑Yes
Bipolar Disorder	❑No	❑Yes

CARDIOVASCULAR

Vascular Disease	❑No	❑Yes
Heart Disease	❑No	❑Yes
Stroke	❑No	❑Yes
Hypertension	❑No	❑Yes

GASTROINTESTINAL

Crohns Disease	❑No	❑Yes
Colitis	❑No	❑Yes
Ulcer	❑No	❑Yes
Acid Reflux	❑No	❑Yes
Celiac	❑No	❑Yes

GASTROINTESTINAL

Kidney	❑No	❑Yes
Prostate	❑No	❑Yes
STD	❑No	❑Yes
Pregnant	❑No	❑Yes
Nursing	❑No	❑Yes
Herpes	❑No	❑Yes
Chlamydia	❑No	❑Yes

Muscular/Skeletal

Arthritis	❑No	❑Yes
Fibromyalgia	❑No	❑Yes
Muscular Dystrophy	❑No	❑Yes
Ankylosing Spondylitis	❑No	❑Yes
Osteoporosis	❑No	❑Yes
Gout	❑No	❑Yes

Integumentary

Eczema	❑No	❑Yes
Rosacea	❑No	❑Yes
Psoriasis	❑No	❑Yes
Herpes Simplex	❑No	❑Yes
Herpes Zoster	❑No	❑Yes

ENDOCRINE

Type I Diabetes	❑No	❑Yes
Type II Diabetes	❑No	❑Yes
Thyroid Dysfunction	❑No	❑Yes

Hematologic/Lymphatic

Anemia	❑No	❑Yes
Ulcer	❑No	❑Yes
Hypercholesteremia	❑No	❑Yes

ALLERGIC/IMMUNOLOGIC

Rheumatoid Arthritis	❑No	❑Yes
Lupus	❑No	❑Yes
Sjogrens Syndrome	❑No	❑Yes

Are you allergic to any medications? If yes, please list:_____

List any medications you take:_____

_____

Social History ***This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*** ❑ Yes, I would prefer to discuss my social history information directly with the doctor

Do you use tobacco products? ❑No ❑Yes If yes, type/amount/how long:_____

Do you drink alcohol? ❑No ❑Yes If yes, type/amount/how long:_____

Do you use illegal drugs? ❑No ❑Yes If yes, type/amount/how long:_____