

Dr. Matthew Burgess

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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 | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Dry Eye | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Age-related Macular Degeneration | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Eye infection/inflammation/allergy | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Glaucoma | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Floaters/Flashes in Vision | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Diabetes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Iritis/Uveitis | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Diabetic Retinopathy | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Retinal degenerations | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Are you experiencing any of the following eye concerns?

- | | | |
|-------------|-----------------------------|------------------------------|
| Redness | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Burning | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Itching | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Tearing | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Discharge | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Other _____ | | |

Are you having any of the following vision concerns?

- | | | | | | |
|------------------------------|-----------------------------|------------------------------|------------------------|-----------------------------|------------------------------|
| Blurred vision | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Poor night vision | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Eyestrain | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Bothersome night glare | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Eye pain | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Double vision | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Severe sensitivity to lights | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Total loss of vision | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Headaches | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | |

Family History

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

<u>DISEASE/CONDITION</u>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<u>RELATIONSHIP TO YOU</u>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____

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: _____