

Health History Report

Name (last, first, MI) _____ Todays Date _____

Address _____ Gender M F

City _____ State _____ Zip _____

Phone (home) _____ (work) _____ (cel) _____

Birthdate _____ SSN _____

Employer _____ Responsible Party _____

Insured's Employer _____ Insured's Name/ Birthdate _____

E-mail address _____

(We will occasionally use e-mail to inform our patients of appointments, specials, notifications of eyeglass or contact lens orders, or interesting vision news. We will never abuse or sell the address. If you do not wish to receive messages from our office, please check here)

Eye and Health History

Please indicate if you or any members of your family have a history of any of the following conditions.

	Self	Family (relationship)		Self	Family (relationship)
cataract	<input type="checkbox"/>	<input type="checkbox"/>	blindness	<input type="checkbox"/>	<input type="checkbox"/>
glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	cancer	<input type="checkbox"/>	<input type="checkbox"/>
macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
retinal disease	<input type="checkbox"/>	<input type="checkbox"/>	diabetes	<input type="checkbox"/>	<input type="checkbox"/>
eye turn/lazy eye	<input type="checkbox"/>	<input type="checkbox"/>	respiratory conditions	<input type="checkbox"/>	<input type="checkbox"/>

Family Physician/clinic _____

Medical History

Please list any other medical conditions you may have.

Do you use:

tobacco no yes #/day
alcohol no yes #/week

(women) Are you pregnant? no yes/months

Allergies, environmental or medications (please list)

none

Medications (please list)

none

Eye History-Reason for todays visit

Have you ever had any injury or surgery to your eyes?(explain) _____

Do you wear glasses now? Yes No

How old is your current pair? _____

Worn for reading distance both

Do you wear contact lenses now? Yes No

Have you ever worn contacts? Yes No

How recently? _____

How long since your last exam? _____

Previous Eye Doctor _____

If you have been a patient of Drs. Goga, Sarazen, or Marquardt at a different location please indicate:

Name of Doctor _____

Date/ Location of Visit _____

Reason for visit _____

If you are a new patient, please tell us why you chose Envision Eyecare.

Signed by _____

Information given by self parent/guardian