ENVISION EYECARE PATIENT INFORMATION

Welcome to Envision Eyecare! For faster service, please complete **BOTH SIDES** of this form prior to your appointment. We look forward to being the one destination for your eyes.

Name (last, first, middle)_____

Preferred Name (e.g. Jim vs James)_____Date of Birth_____

SSN_____Parent/Guardian (if applicable)_____

Mailing Address_____

City_____State_____Zip_____

Home Phone_____Mobile Phone_____

Work Phone_____E-Mail_____

How do you prefer to be contacted? ☐ Home Phone ☐ Work Phone ☐ E-Mail ☐ Mobile Phone ☐ Text Message ☐ US Mail

Occupation & Employer:_____

Primary Care Physician:_____

Clinic:_____

Last Eye Exam:_____

Clinic:_____

Gender
- ☐ Male
- ☐ Female

Race/Ethnicity
- ☐ White (not Hispanic)
- ☐ Hispanic/Latino
- ☐ African-American
- ☐ Asian
- ☐ American Indian
- ☐ Other
- ☐ Prefer not to answer

Marital Status
- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Widowed
- ☐ Other

Language Preference
- ☐ English
- ☐ Spanish
- ☐ Hmong
- ☐ Other

Current corrective eyewear: ☐ Glasses ☐ Contact Lenses ☐ None

Reason for visit:_____

Are you interested in: ☐ Glasses ☐ Sunglasses ☐ Contact Lenses ☐ LASIK

Medical Insurance Company_____Vision Insurance Company_____

Insured Name_____

Insured Employer_____

Insured SSN_____Insured Date of Birth_____

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other:

☐ By checking this box, I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I understand that I am financially responsible for all charges, regardless of insurance benefits. Payment is due at the time services are rendered.

☐ By checking this box, I acknowledge that I have received a copy of Envision Eyecare's Notice of Privacy Practices (HIPAA Compliance)

Patient or Parent/Guardian Signature_____**Date**_____

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

(OVER PLEASE)

EYE AND HEALTH HISTORY

Please indicate if you or a family member have/had any of the following conditions:

EYE	self	family (relationship)
Glaucoma	☐	☐
Cataracts	☐	☐
Lazy Eye/Crossed Eyes	☐	☐
Macular Degeneration	☐	☐
Diabetic Eye Disease	☐	☐
Eye Surgery (incl LASIK)	☐	☐
CANCER	☐	☐

HEALTH	self	family (relationship)
Diabetes	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐

if self _____ (type) if family _____ (type) / _____ (relationship to patient)

HEALTH REVIEW

Please indicate if you have a current history of any of the following conditions or indicate **NONE** if it does not apply. You may also share information with the technician or doctor during the exam if you are uncomfortable filling out the form.

ALLERGIC/IMMUNOLOGIC
- ☐ Drug Allergy
- ☐ Environmental Allergy
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Other:
- ☐ **NONE**

CARDIOVASCULAR
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Stroke
- ☐ Vascular Disease
- ☐ Other:
- ☐ **NONE**

CONSTITUTIONAL
- ☐ Developmental Disability
- ☐ Weight Loss
- ☐ Fever
- ☐ Fatigue
- ☐ Trauma
- ☐ Pregnancy (____ wks)
- ☐ Other:
- ☐ **NONE**

EAR, NOSE, THROAT
- ☐ Upper Respiratory Infection
- ☐ Ear Ache
- ☐ Runny Nose
- ☐ Sore Throat
- ☐ Ringing/Tinitus
- ☐ Other:
- ☐ **NONE**

ENDOCRINE
- ☐ Diabetes, non-insulin dependent
- ☐ Diabetes, insulin dependent
- ☐ Thyroid Dysfunction
- ☐ Hormonal Dysfunction
- ☐ Other:
- ☐ **NONE**

GASTROINTESTINAL
- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer:
- ☐ Digestive Problems
- ☐ Other:
- ☐ **NONE**

HEMATOLOGIC/ LYMPHATIC
- ☐ Anemia
- ☐ Large Volume Blood Loss
- ☐ Leukemia
- ☐ Other:
- ☐ **NONE**

RESPIRATORY
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Other:
- ☐ **NONE**

SMOKING STATUS
- ☐ Daily smoker
- ☐ Occasional smoker
- ☐ Former smoker
- ☐ Never smoked

MUSCULOSKELETAL
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Ankylosing Spondylitis
- ☐ Other:
- ☐ **NONE**

NEUROLOGICAL
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Alzheimer's
- ☐ Parkinson's
- ☐ Cerebrovascular (stroke)
- ☐ Other:
- ☐ **NONE**

PSYCHIATRIC
- ☐ Depression
- ☐ Panic Disorder
- ☐ Schizophrenia
- ☐ Other:
- ☐ **NONE**

SKIN
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Other:
- ☐ **NONE**

GENITOURINARY
- ☐ STD, viral herpetic, chlamydia
- ☐ Other:
- ☐ **NONE**

ALLERGIES AND MEDICATIONS

Please list any **ALLERGIES** you have, including seasonal, environmental or medications: ☐ **NONE**

Please list any prescription or over the counter **MEDICATIONS** you are currently taking: ☐ **NONE**

Please list any other health issues not indicated above:

Reviewed and Changes Noted

Date_____Initial_____

Date_____Initial_____

Date_____Initial_____