

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: _____

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)

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

EYE AND HEALTH HISTORY

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

EYE	self	family (relationship)	HEALTH	self	family (relationship)
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Lazy Eye/Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetic Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Eye Surgery (incl LASIK)	<input type="checkbox"/>	<input type="checkbox"/>			
CANCER	<input type="checkbox"/>	<input type="checkbox"/>			

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/Tinnitus
- 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 _____