

**WELCOME TO ENVISION EYECARE.**  
**We appreciate you choosing us for your professional eye care.**

Ms., Miss Mr., Mrs. (last) \_\_\_\_\_ (first) \_\_\_\_\_ (mi) \_\_\_\_\_ Today's Date \_\_\_\_\_  
Nickname \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_  
Home Address: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ **Email:** \_\_\_\_\_  
Preferred Phone Number: Cell Home Work Race: \_\_\_\_\_ Preferred Language: \_\_\_\_\_  
Have we taken care of your family members?  Yes Whom? \_\_\_\_\_  
May we thank someone for referring you?  Yes Whom? \_\_\_\_\_  
Medical Insurance: \_\_\_\_\_ Vision Insurance: \_\_\_\_\_  
Policyholders Name: \_\_\_\_\_ Policyholder's Employer: \_\_\_\_\_

**LIFESTYLE QUESTIONNAIRE** This will allow us to make recommendations for your specific eye care needs!

What is the Reason(s) for your Visit Today? \_\_\_\_\_  
\_\_\_\_\_ When was your last eye exam? \_\_\_\_\_

Are you having vision problems without glasses?  Yes, distance  Yes, computer  Yes, near  No

**Glasses** Do you wear glasses?  Yes  No If no, skip to the contact lenses section.

Are you having problems with your glasses?  Yes, distance  Yes, computer  Yes, near  No

Are you interested in getting new glasses?  Yes  If my prescription changes  No

Do your glasses have an anti-glare lenses?  Yes  No Do you have prescription sunglasses?  Yes  No

**Contact Lenses** Do you wear contact lenses?  Yes  No If no, do you want to try them today?  Yes  No

Are you interested in colored contacts?  Yes **Refractive Surgery** Are you interested in laser surgery?  Yes

**Activities:** Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Is it difficult to see when driving during the day?  Yes  No At night?  Yes  No

How many hours per day do you use the computer? \_\_\_\_\_

Do you spend time outdoors?  Yes  No How many hours per week? \_\_\_\_\_

What hobbies do you enjoy? \_\_\_\_\_

Do these activities strain your eyes?  Yes  No \_\_\_\_\_

(Please do not write below this line – For Office Use only) Proceed to back page

Notes \_\_\_\_\_ Insurance \_\_\_\_\_

Glasses \_\_\_\_\_ Contacts \_\_\_\_\_

DIL  PA  Trop/ Phen  Caine  Cyclate  Decline Time \_\_\_\_\_ OPTOS  Yes  No  ? OCT  Yes  No  ?

Notes \_\_\_\_\_

**Recommend:** A/R, Trans, \_\_\_\_\_ Prog, SV \_\_\_\_\_, Comp/Read, Sport, Safety, Sun, Polz, BF TF  
RTC: 1 year preappoint \_\_\_\_\_ @DISP

**Social History** Please check the box if you prefer to discuss the following information with the doctor only.

Do you use tobacco products?  Yes, every day  Yes, some day  No, never  No, former smoker

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

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

**Ocular History** Do you have any eye problems?  Cataracts  Macular Degeneration  Glaucoma  Diabetic

Dry Eye  Eye Infections  Allergies  Floaters  Flashes  Iritis /Uveitis  Retinal Detachment  Redness

Burning  Itching  Watery Eyes  Mucous Discharge  Eyestrain/Tired Eyes  Blurred Vision  Eye Pain

Light Sensitivity  Headaches  Poor Night Vision  Glare  Double Vision  Vision Loss  Eye Surgery  Lazy eye

Eye turn /Patching  Keratoconus  Eye Injury  Nystagmus  Droopy eyelid  Other \_\_\_\_\_

**Medical History:** Name of Medical Doctor: \_\_\_\_\_ Last Medical Exam: \_\_\_\_\_

**Medications:**  No Medications  Provided List \_\_\_\_\_

Do you have any allergies?  Yes  No If yes, please list. \_\_\_\_\_

List all major injuries, surgeries and/or hospitalizations: \_\_\_\_\_

Are you pregnant?  Yes  No  Maybe Are you nursing?  Yes  No

---

**Review of Systems** - Please circle all that apply or fill-in the blank for those not listed.

**CONSTITUTIONAL:** Developmental disabilities / Fatigue / Cancer, Type \_\_\_\_\_ / \_\_\_\_\_

**EARS, NOSE, THROAT:** Hearing loss / Sinusitis / Dry mouth / Laryngitis / \_\_\_\_\_

**NEUROLOGICAL:** Multiple sclerosis / Epilepsy / Cerebral Palsy / Tumor / Migraine / \_\_\_\_\_

**PSYCHIATRIC:** Depression / ADHD / Anxiety / Bipolar / \_\_\_\_\_

**CARDIOVASCULAR:** High blood pressure / Stroke / Heart disease \_\_\_\_\_

**RESPIRATORY:** Asthma / Bronchitis / Emphysema / Chronic obstruction / Sleep Apnea / \_\_\_\_\_

**GASTROINTESTINAL:** Crohn's / Colitis / Ulcer / Acid reflux / Celiac disease / \_\_\_\_\_

**GENITOURINARY:** Kidney disease / Prostate disease / Herpes / Chlamydia / \_\_\_\_\_

**MUSCULOSKELETAL:** Arthritis / Fibromyalgia / Ankylosing Spondylitis /Gout / \_\_\_\_\_

**INTEGUMENTARY:** Eczema / Rosacea / Psoriasis / Cold Sores / Shingles / \_\_\_\_\_

**ENDOCRINE:** Type 2 Diabetes / Type 1 Diabetes / Hypothyroid / Hyperthyroid – Grave's Disease / \_\_\_\_\_

**HEMOTOLOGIC / LYMPHATIC:** Anemia / Blood Loss / Ulcer / High Cholesterol / \_\_\_\_\_

**ALLERGIC / IMMUNOLOGIC:** Rheumatoid Arthritis / Lupus / Sjogren's / HIV / Gonorrhea / Hepatitis / Syphilis / \_\_\_\_\_

**Family History** List the family member(s) that has/had the following: (Ex. Mother, Grandparent, etc)

Heart Disease \_\_\_\_\_

High Blood Pressure \_\_\_\_\_

Diabetes \_\_\_\_\_

Cancer \_\_\_\_\_

Thyroid Disease \_\_\_\_\_

Cataract \_\_\_\_\_

Glaucoma \_\_\_\_\_

Macular Degeneration \_\_\_\_\_

Lazy Eye / Amblyopia \_\_\_\_\_

Eye Turn / Strabismus \_\_\_\_\_

Nystagmus \_\_\_\_\_

Retinal Detachment / Disease \_\_\_\_\_

Arthritis \_\_\_\_\_

Lupus \_\_\_\_\_