# Envision Eyecare
# Welcome To Our Office

**Welcome to Envision Eyecare. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.**

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name _____ MI _____ Last Name _____ Preferred Name _____

Street Address _____ City _____ State _____ Zip _____

Social Security Number _____ Date of Birth _____ Home Phone - Include Area Code _____ Work Phone _____

Email Address _____ Spouse or Parent(s) Name _____ Person Responsible for Account _____

Emergency Contact _____ Emergency Phone _____

How were you referred to our office?

☐ Phone Book ☐ Web Search ☐ Advertisement ☐ Patient (Please Name) _____

☐ Insurance Listing ☐ Drive by ☐ Other _____ ☐ Doctor (Please Name) _____

**VISION INSURANCE INFORMATION**

Name and Address of Primary Insurance Company _____ City _____ State _____ Zip _____

M ☐ F ☐ _____ _____

Insured's First Name MI Insured's Last Name

Insured's Identification Number _____ Group Number _____ Insured's Date of Birth _____

**Patient Relationship to Insured**

☐ Self ☐ Spouse ☐ Child ☐ Other

**Patient Status** ☐ Single ☐ Married ☐ Other

☐ Full Time Student ☐ Part Time Student ☐ Employed

**Please Read:**

I acknowledge that a copy of Envision Eyecare's Financial Agreement has been made available to me. I understand that payment is expected at the time services are rendered. Accounts over 30 days past due are subject to late fees, interest and collection fees.

I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. Payment from my insurance is to be paid directly to Envision Eyecare. I understand that I will ultimately be responsible for any bill incurred in this office regardless of insurance.

Signature _____ Date _____

## Acknowledgement of Receipt

I acknowledge that Envision Eyecare, L.L.C. has made their Notice of Privacy Practices available to me.

Signature _____ Date: _____

Name

# Envision Eyecare
## PATIENT HISTORY AND INFORMATION

**PRIMARY CARE PHYSICIAN**

Primary Care Physician and Clinic Name

Address of Primary Care Physician City State Zip Phone

**REFERRING PHYSICIAN**

Referring Physician and Clinic Name

Address of Referring Physician City State Zip Phone

**HEALTH HISTORY**

What is the main reason for today's exam ? When was your last exam ?

When was your last health exam ?

Past Illnesses or Injuries:

Past Surgeries:

Current Medications:

Current Eye Drops:

Medicines that cause reactions or sensitivities:

Specific Allergies:

**EYE HISTORY**

| | | | | | |
|---|---|---|---|---|---|
| Glaucoma | ○ Yes ○ No | Dryness | ○ Yes ○ No | Strabismus (Crossed Eyes) | ○ Yes ○ No |
| Cataract | ○ Yes ○ No | Excess Tearing/Watering | ○ Yes ○ No | Blurred Vision Distance | ○ Yes ○ No |
| Macular Degeneration | ○ Yes ○ No | Eye Pain or Soreness | ○ Yes ○ No | Blurred Vision Near | ○ Yes ○ No |
| Retinal Detachment | ○ Yes ○ No | Foreign Body Sensation | ○ Yes ○ No | Distorted Vision (halos) | ○ Yes ○ No |
| Color Blindness | ○ Yes ○ No | Infection of Eye or Lid | ○ Yes ○ No | Double Vision | ○ Yes ○ No |
| Headaches | ○ Yes ○ No | Itching | ○ Yes ○ No | Floaters or Spots | ○ Yes ○ No |
| Glare/Light Sensitivity | ○ Yes ○ No | Mucous Discharge | ○ Yes ○ No | Fluctuating Vision | ○ Yes ○ No |
| Tired Eyes | ○ Yes ○ No | Drooping Eyelid | ○ Yes ○ No | Loss of Vision | ○ Yes ○ No |
| Amblyopia (Lazy Eye) | ○ Yes ○ No | Redness | ○ Yes ○ No | Loss of Side Vision | ○ Yes ○ No |
| Burning | ○ Yes ○ No | Sandy or Gritty Feeling | ○ Yes ○ No | | |

**GENERAL HEALTH CONDITION**

| | | | | | |
|---|---|---|---|---|---|
| Fever | ○ Yes ○ No | Respiratory (Asthma) | ○ Yes ○ No | Anxiety or Depression | ○ Yes ○ No |
| Weight Loss | ○ Yes ○ No | Gastrointestinal | ○ Yes ○ No | Endocrine (Thyroid, Diabetes) | ○ Yes ○ No |
| Other Symptoms | ○ Yes ○ No | Kidney | ○ Yes ○ No | Blood/Lymph | ○ Yes ○ No |
| Ears,Nose,Throat | ○ Yes ○ No | Muscles,Bones,Joints | ○ Yes ○ No | Allergic | ○ Yes ○ No |
| Cardiovascular (high blood pressure etc.) | ○ Yes ○ No | Skin | ○ Yes ○ No | Are you? | ☐ Pregnant ☐ Nursing |
| | | Neurological (Multiple Sclerosis) | ○ Yes ○ No | | |

**FAMILY HISTORY**

| | | | | | |
|---|---|---|---|---|---|
| Amblyopia (Lazy Eye) | ○ Yes ○ No | Retinal Detachment | ○ Yes ○ No | High Blood Pressure | ○ Yes ○ No |
| Blindness | ○ Yes ○ No | Strabismus (Eye Turn) | ○ Yes ○ No | Kidney Disease | ○ Yes ○ No |
| Cataract(s) | ○ Yes ○ No | Arthritis | ○ Yes ○ No | Lupus | ○ Yes ○ No |
| Color Blindness | ○ Yes ○ No | Cancer | ○ Yes ○ No | Stroke | ○ Yes ○ No |
| Glaucoma | ○ Yes ○ No | Diabetes | ○ Yes ○ No | Thyroid Disease | ○ Yes ○ No |
| Macular Degeneration | ○ Yes ○ No | Heart Disease | ○ Yes ○ No | Others | ○ Yes ○ No |

Name

# Envision Eyecare

## MEDICAL HISTORY QUESTIONAIRE

**SOCIAL HISTORY**

Current Occupation : _____ Years _____ Employer _____

**SPECTACLE LENS HISTORY**

Do you use a computer? ○ Yes ○ No How many hours/day? _____ Distance from Computer? _____

Do you drive? ○ Yes ○ No Mileage to work each way? _____ Do you have glare problems? ○ Yes ○ No

Do you have visual difficulty when driving? ○ Yes ○ No

Do you have problems with night vision? ○ Yes ○ No

Do you currently wear glasses ? ○ Yes ○ No Since _____

Type of glasses ☐ Full Time ☐ Part Time ☐ Distance ☐ Close

Glasses Owned

☐ Single Vision ☐ Bifocals ☐ Trifocals ☐ Back-up Glasses ☐ Safety Glasses ☐ Sports Glasses ☐ Progressive

Have you had trouble in the past with glasses? ○ Yes ○ No _____

Do you wear sunglasses? ○ Yes ○ No Are your sun glasses your current prescription ? ○ Yes ○ No

**SPECIAL EYEWEAR NEEDS**

☐ Computer (special prescriptions, special anti-glare tints or coatings) ☐ Safety Glasses (gardening, woodworking, welding)
☐ Occupational (mechanics, plumbers, pilots) ☐ Sports/Hobbies (racquet sports, motorcycle)

**CONTACT LENS HISTORY**

Have you ever tried to wear contact lenses? ○ Yes ○ No Reason for stopping? _____

Do you currently wear contact lenses? ○ Yes ○ No Since _____

If not a contact lens wearer, are you interested in trying contact lenses at this time ? ○ Yes ○ No

Type and brand of contact lenses _____ Today's wearing time ? _____

How many hours/day ? _____ How many days/week ? _____

**Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT**

| | Right | Left | | Right | Left | | Right | Left |
|---|---|---|---|---|---|---|---|---|
| Lens Comfort | | | Distance Vision | | | Near Vision | | |

What Solutions do you use? Cleaner _____ Disinfectant _____ Enzyme _____

**SOCIAL HISTORY**

Do you use nutritional supplements (vitamins etc.)? ○ Yes ○ No

Do you engage in regular exercise? ○ Yes ○ No

Do you drink alcohol ? If yes, how much/often : ○ No ○ Occasional ○ 1 per day ○ 2-3/day ○ 4+/day

Do you smoke ? If yes, how much/often : ○ No ○ Occasional ○ 1/2 pack/day ○ 1 pack/day ○ 1+ pack

Method of Tobaco Intake : ○ Smoking ○ Chewing

Do you use Illegal Drugs : ○ Yes ○ No

Hobbies/ Interests : _____