ENVISION EYECARE

Missoula • Montana

Welcome!

Name:____ Date of Birth:___ / ___ /___

Last Eye Exam: _____ / _____ / _____   Today's Date:___ / ___ /___

Ocular History **Have you ever been diagnosed with any of the following conditions?**

Cataract	❑	Dry Eye	❑	
Age-related Macular Degeneration	❑	Eye infection/inflammation/allergy	❑	
Glaucoma	❑	Floaters/Flashes in vision	❑	❑ NONE
Diabetes	❑	Iritis/Uveitis	❑	
Diabetic Retinopathy	❑	Retinal disease/Degenerations	❑	

Please list any eye surgeries or injuries you have had: ____________________________________

Are you experiencing any of the following eye and vision concerns?

Redness	❑	Blurred vision:	❑	
Burning	❑	Eyestrain	❑	
Itching	❑	Eye Pain	❑	
Tearing	❑	Severe Sensitivity to Lights	❑	❑ NONE
Discharge	❑	Headaches	❑	
Poor Night Vision	❑	Bothersome Night Glare	❑	
Double vision	❑	Total Loss of Vision	❑	

Other____

Family History (Family History Unknown ❑)

Please note any known family history (parents, grandparents, siblings, children, living or deceased) for the following:

DISEASE/CONDITION		**RELATIONSHIP TO YOU**
Crossed Eyes	❑	____________________________
Glaucoma	❑	____________________________
Macular Degeneration	❑	____________________________
Retinal Detachment/Disease	❑	____________________________
Diabetes	❑	____________________________
Cancer	❑	____________________________
High Blood Pressure	❑	____________________________

PERSONAL HEALTH HISTORY Do you currently or have you ever had any problems in the following areas?

CONSTITUTIONAL

Fatigue Syndrome ❑No ❑Yes

Cancer ❑No ❑Yes

EARS, NOSE, THROAT

Hearing Loss ❑No ❑Yes

Sinusitis ❑No ❑Yes

Dry mouth ❑No ❑Yes

Laryngitis ❑No ❑Yes

NEUROLOGICAL

MS ❑No ❑Yes

Epilepsy ❑No ❑Yes

Cerebral Palsy ❑No ❑Yes

Tumor ❑No ❑Yes

Stroke ❑No ❑Yes

Migraines ❑No ❑Yes

PSYCHIATRIC

Depression ❑No ❑Yes

ADHD ❑No ❑Yes

Anxiety Disorder ❑No ❑Yes

Bipolar Disorder ❑No ❑Yes

CARDIOVASCULAR

Vascular Disease ❑No ❑Yes

Heart Disease ❑No ❑Yes

Stroke ❑No ❑Yes

Hypertension ❑No ❑Yes

GASTROINTESTINAL

Crohns Disease ❑No ❑Yes

Colitis ❑No ❑Yes

Ulcer ❑No ❑Yes

Acid Reflux ❑No ❑Yes

Celiac ❑No ❑Yes

ALLERGIC/IMMUNOLOGIC

Rheumatoid Arthritis ❑No ❑Yes

Lupus ❑No ❑Yes

Sjogrens Syndrome ❑No ❑Yes

GENITOURINARY

Kidney ❑No ❑Yes

Prostate ❑No ❑Yes

STD ❑No ❑Yes

Currently Pregnant ❑No ❑Yes

Currently Nursing ❑No ❑Yes

Herpes ❑No ❑Yes

Chlamydia ❑No ❑Yes

MUSCULAR/SKELETAL

Arthritis ❑No ❑Yes

Fibromyalgia ❑No ❑Yes

Muscular Dystrophy ❑No ❑Yes

Ankylosing Spondylitis ❑No ❑Yes

Osteoporosis ❑No ❑Yes

Gout ❑No ❑Yes

INTEGUMENTARY ❑NONE

Eczema ❑No ❑Yes

Rosacea ❑No ❑Yes

Psoriasis ❑No ❑Yes

Herpes Simplex ❑No ❑Yes

Herpes Zoster ❑No ❑Yes

ENDOCRINE

Type I Diabetes ❑No ❑Yes

Type II Diabetes ❑No ❑Yes

Thyroid Dysfunction ❑No ❑Yes

HEMATOLOGIC/LYMPHATIC

Anemia ❑No ❑Yes

Ulcer ❑No ❑Yes

High Cholesterol ❑No ❑Yes

RESPIRATORY

Current Smoker ❑No ❑Yes

History of Smoking ❑No ❑Yes ______years

Asthma ❑No ❑Yes

Emphysema/COPD ❑No ❑Yes

Sleep Apnea ❑No ❑Yes

Are you allergic to any medications? If yes, please list:____

____

Current Prescriptions: ____

____