WELCOME TO ENVISION EYECARE.

We appreciate you choosing us for your professional eye care.

Child's Name: (last)_____ (first)_____ (mi)_____Today's Date_____
Nickname:_____Home Address:_____
City:_____ ST:_____ Zip: _____ Date of Birth: _____/_____/_____
Home Phone: (_____)_____ Cell Phone: (_____)_____**Email:** _____
Preferred Phone Number: Cell Home Work Race:_____ Preferred Language: _____
Parent's Name:_____Have we taken care of other family members? _____
May we thank someone for referring you?_____Medical Insurance:_____
Vision Insurance:_____ Policyholder's Social Security # : _____
Policyholder's Name:_____Policyholder's Employer: _____

LIFESTYLE QUESTIONAIRE

This will allow us to make recommendations for your child's eye care needs!

What are the reasons for your child's visit today?_____
_____
_____When was your child's last eye exam? _____
Is your child having vision problems without glasses? ❑Yes, distance ❑Yes, computer ❑Yes, near ❑ No

Glasses
Does your child wear glasses? ❑ Yes ❑ No **(If no, skip to next section)**
Is your child having vision problems with glasses? ❑ Yes, distance ❑ Yes, computer ❑ Yes, near ❑ No
Is your child happy with the comfort of the glasses? ❑ Yes ❑ No How old is your present pair of lenses? _____
Is your child interested in getting new glasses? ❑ Yes ❑ Only if the prescription changes ❑ No
Do the glasses have an anti-reflective coating? ❑ Yes ❑ No Do the glasses have changeable tint? ❑ Yes ❑ No
Does your child have prescription sunglasses? ❑ Yes ❑ No

Contact Lenses
Does your child currently wear contacts? ❑ Yes ❑ No If no, is your child interested in trying contacts? ❑ Yes ❑ No

Hobbies and Activities:
Child's current grade in school _____ Does your child know numbers and letters? ❑ Yes ❑ No
Does your child use the computer? ❑ Yes ❑ No How many hours per day? _____
Does your child spend time outdoors? ❑ Yes ❑ No How many hours per week?_____
What hobbies does your child enjoy? ❑ Reading ❑ Video Games ❑ Sports_____
❑ Other _____ Do these activities strain your child's 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

Ocular History *Does your child have 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_____

Does your child: ❑ Reverse Words /Letters When Reading ❑ Skip or Reread Words or Lines ❑ Blink Excessively ❑ Frown or Squint ❑Use Finger When Reading ❑ Tilt or Move Head When Reading ❑ Close or Cover One Eye

Medical History: Name of Child's Medical Doctor:_____ Last Medical Exam:_____

List any medications your child takes and the reason (include Over the Counter)_____

_____

Does your child have any allergies to medications? ❑ Yes ❑ No If yes, please list name of the medication and reaction:

_____

List all major injuries, surgeries and/or hospitalizations: _____

_____

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

CONSTITUTIONAL: Developmental disabilities / Fatigue / Cancer, Type_____/Other_____
EARS, NOSE, THROAT: Hearing loss / Sinusitis / Dry mouth / Laryngitis / Other_____
NEUROLOGICAL: Multiple sclerosis / Epilepsy / Cerebral Palsy / Tumor / Migraine / Other: _____
PSYCHIATRIC: Depression / Attention deficit (ADHD) / Anxiety / Bipolar Other :_____
CARDIOVASCULAR: High blood pressure / Stroke / Heart disease / Vascular disease / Congestive heart failure Other:_____
RESPIRATORY: Asthma / Bronchitis / Emphysema / Chronic obstruction / Sleep Apnea / Other:_____
GASTROINTESTINAL: Crohn's / Colitis / Ulcer / Acid reflux / Celiac disease / Other: _____
GENITOURINARY: Kidney disease / Prostate disease or cancer / Pregnant / Herpes / Chlamydia / Other: _____
MUSCULOSKELETAL: Osteoarthritis / Arthritis / Fibromyalgia / Muscular dystrophy / Ankylosing Spondylitis Osteoporosis / Gout / Other: _____
INTEGUMENTARY: Eczema / Rosacea / Psoriasis / Cold Sores / Shingles / Other:_____
ENDOCRINE: Type 2 Diabetes / Type 1 Diabetes / Hypothyroid / Hyperthryoid – Grave's Disease / Hormone Problems Other: _____
HEMOTOLOGIC / LYMPHATIC: Anemia / Blood Loss / Ulcer / High Cholesterol / Other:_____
ALLERGIC / IMMUNOLOGIC: Food Allergies / Fluorescein Allergy / Environmental Allergies / Rheumatoid Arthritis / Lupus / Sjogren's / HIV / Gonorrhea / Hepatitis / Syphilis / Other: _____

Family History **List the family member's relationship to your child:** ***(Ex. Mother, Grandparent, etc)***

Heart Disease _____ **Macular Degeneration** _____
High Blood Pressure_____ **Lazy Eye / Amblyopia**_____
Diabetes _____ **Eye Turn / Strabismus** _____
Cancer _____ **Nystagmus** _____
Thyroid Disease_____ **Retinal Detachment / Disease**_____
Cataract _____ **Arthritis** _____
Glaucoma_____ **Lupus** _____