EnvisionSEE, LLC 206 Kings Highway East
Ada Noh, O.D. Haddonfield, NJ 08033

**Patient History**

|  |  |
| --- | --- |
| Patient’s Full Legal Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ SSN# \_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | Marital Status ❏ M ❏ S ❏ D ❏ W Race ❏ White ❏ African American ❏ Asian ❏ Other ❏ Decline to Answer Ethnicity ❏ Hispanic or Latino ❏ Non-Hispanic or Latino ❏ Decline to AnswerOccupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Were you referred to our office? YES NOIf yes, referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| MEDICAL HISTORYLast PCP Visit \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_ PCP Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Current Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Allergies to medications?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pregnant or breastfeeding? YES NOUse tobacco products? YES NODo you or your family member currently have, or ever had any of the following? Please check the box.

|  |  |  |  |
| --- | --- | --- | --- |
|  | YES | NO | FAMILY |
| High Blood Pressure |  |  |  |
| High Cholesterol |  |  |  |
| Diabetes |  |  |  |
| Sleep Apnea |  |  |  |
| Hepatitis A/B/C |  |  |  |
| Herpes Simplex |  |  |  |
| Herpes Zoster/Shingles |  |  |  |
| Rheumatoid Arthritis |  |  |  |
| Multiple Sclerosis |  |  |  |
| Lupus |  |  |  |

 | OCULAR HISTORYLast Eye Exam \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Prev. Eye Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Wear glasses? YES NOWear contacts? YES NOHave you or a family member experienced, or been treated for, any of the following? Please check the box.

|  |  |  |  |
| --- | --- | --- | --- |
|  | YES | NO | FAMILY |
| Crossed eye |  |  |  |
| Glaucoma |  |  |  |
| LASIK/PRK |  |  |  |
| Macular Degeneration |  |  |  |
| Retinal Detachment |  |  |  |

Are you currently experiencing any of the following? Circle all that apply: Blurry Vision near or distance Burning Double Vision Dryness Excess Tearing/Watering Eye Pain, Soreness, or Irritation Floaters or Spot Headaches Itching Light Flashes Light Sensitivity Redness |

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_ Doctors’ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_