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

**Patient History**

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| 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 Answer  Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Were you referred to our office? YES NO If yes, referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| MEDICAL HISTORY  Last PCP Visit \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_  PCP Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Allergies to medications?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Pregnant or breastfeeding? YES NO  Use tobacco products? YES NO  Do 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 HISTORY  Last Eye Exam \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_  Prev. Eye Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Wear glasses? YES NO  Wear contacts? YES NO  Have 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_