ENVISION OPTIQUE

Welcome to the Office

Dr. Michael R. Obregon
Board Certified Optometric Physician

Please fill out as completely as possible, and let our staff know of any questions.

GENERAL INFORMATION

Full Name: _____
LAST FIRST

Address: _____
_____
_____

Sex (M/F): _____ Date of Birth: _____

Employer: _____
Occupation: _____

Primary Ph #: _____
Secondary Ph#: _____
Email Address: _____

Preferred Method of Contact:
❑ Phone ❑ Text ❑ Email

INSURANCE INFORMATION

VISION INSURANCE:
Name of Insurance: _____
Policy/ ID #: _____
Are you the Primary Insured? (Y / N) _____
If not Primary Insured – Name of Primary: _____
Relationship to Primary Insured: _____

MEDICAL INSURANCE:
Name of Insurance: _____
Policy/ ID #: _____
Are you the Primary Insured? (Y / N) _____
If not Primary Insured – Name of Primary: _____
Relationship to Primary Insured: _____

REASON FOR THE VISIT

Why are you here today? (ex: contact lenses, eye problems, new glasses, routine exam, etc.) _____
_____
How did you hear about us? insurance website, friend, family(please list name), social media _____
Does your work require special vision needs? (Y / N) Do you have persistent dryness in your eyes? (Y / N)
Interested in corrective laser surgery? (Y / N) Interested in eliminating glasses without surgery? (Y / N)

MEDICAL HISTORY

Please list any **medical conditions** now or in the past: _____
Please list current **medications** (incl. birth control, hormones, eye drops, supplements): _____
Name of Primary Care Physician: _____ Ph#: _____ Date of last Physical: _____
Anything else we should know about? _____

MEDICAL SYSTEMS REVIEW

Please check (✓) each line	Yes	No	Family *(whom?)*
Allergies			
High Blood Pressure			
Heart Disease			
Diabetes			
Gastrointestinal(Digest.)			
Cancer			
Endocrine/ Thyroid			
Ear-Nose-Throat			
Headaches			
Urinary			
Blood/ Lymph Nodes			
Respiratory/ Lungs			
Infectious			

OCULAR HISTORY/SYMPTOMS

Blurred Vision	❑	Yes	❑	No
Double Vision	❑	Yes	❑	No
Tired When Reading	❑	Yes	❑	No
Spots	❑	Yes	❑	No
Cataracts	❑	Yes	❑	No
Eyelid Problems	❑	Yes	❑	No
Glaucoma	❑	Yes	❑	No
Tearing	❑	Yes	❑	No
Surgery	❑	Yes	❑	No
Trauma	❑	Yes	❑	No
Heavy Computer Use	❑	Yes	❑	No
Active Sports/Hobbies	❑	Yes	❑	No

Other:_____