Dr. Gretchen Arneson
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Durango, CO 81301
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Welcome to EnVision Eye Care!

Name:_____Today's Date:___ / ___ /___

Last Eye Exam: _____ / _____ / _____

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:	With glasses ❑	Without glasses ❑
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	❑	_____

Whom may we thank for referring you to our clinic? _____

Please fill out the following information so that the doctor can address your individual vision needs:

Retired ❑ Student ❑ Employed ❑ Other ❑ _____

Occupation_____How many hours are you on the computer?_____

Hobbies/Sports_____

Personal Health History

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

CONSTITUTIONAL

Fatigue	❑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
Premenopause/Menopause	❑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:_____

_____

List any medications you take (prescription or over-the-counter):

_____