Welcome to Eye Envy, Where Style Matters!

Date:___/___/____

Name: (L) __________________________ (F) __________________________

Preferred Name: ________________________

DOB: _____/_____/_____ **Age:** __________ **SSN:** ____________________

Home Address: ____

City, State & Zip:______________________ **Email:** ______________________________

Phone Number: ___________________________ ( )Cell Phone ( )Home Phone

Race: ( )American Indian/ Alaskan Native ( )Asian ( )African American ( )Native Hawaiian/Pacific Islander ( )Caucasian ( )Other __________________ ( )Decline to answer

Ethnicity: ( )Hispanic or Latino ( )Not Hispanic or Latino ( )Decline to answer

Preferred Language: ( )English ( )Spanish ( )Other

Can Eye Envy contact you via text, voicemail, and email? ( )Yes ( )No

Emergency Contact: __________________________ **Phone Number:** ____________________

Relation: ( )Spouse ( )Parent/Guardian ( )Other

Employer: __________________________ **Occupation:**_________________________________

Health History

Do you wear glasses? ( )Yes ( )No

Do you wear contacts? ( )Yes ( )No **If Yes what Brand?** _______________________

Please check any of the following medical conditions that you may have.

( ) None
( ) Diabetes
( ) High Blood Pressure
( ) High Cholesterol
( ) Type 1 Diabetes
( ) Type 2 Diabetes
( ) Thyroid Condition
( ) Pregnant
( ) Nursing
( ) Auto Immune Diseases
( ) Arthritis
( ) Gastrointestinal (Crohns/IBS)

Please list any other medical conditions or illnesses you may have:

____

List any current medications **(Prescriptions & over the counter)** **& eye drops:** ( )None

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List any allergies to medications: ( )None

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Please mark any eye conditions you have:

( ) None
( ) Macular Degeneration
( ) Cataracts
( ) Lazy eye
( ) Glaucoma
( ) Flashers
( ) Floaters
( ) Retinal Detachment

What is your current tobacco use status:

( ) Never Smoker
( ) Current Smoker
( ) Former Smoker
( ) Smokeless Tobacco

Please mark any conditions you have a family history of:

( ) None
( ) Diabetes
( ) High Blood Pressure
( ) Thyroid Condition
( ) Other ____

Please mark any conditions you have a family history of:

( ) None
( ) Glaucoma
( ) Macular Degeneration
( ) Retinal Detachment
( ) Other ____

Height:__________ **Weight:**___________