

To Our New Patient:

First, let me welcome you to this practice. We are delighted you have decided to join us. Our suite has been an optometry practice since 1964, when the first owner moved into this building. I am the third owner, having bought the practice in September 2005. The thrust of this practice has always been to provide very personalized, patient and thorough eye care and I am doing my best to continue and to expand upon this tradition. If you are tired of being treated as a number by doctors whose offices are like factories, then you have come to the right place.

Paperwork. Enclosed are some forms for you to fill out. Please bring them to your appointment.

- History form – This form helps me understand your entire medical situation, since the health of your eyes is so intimately connected to the health of the rest of your body. **If you are having vision problems at the computer, or eye discomfort at the computer, please measure the distance from your eyes to the computer screen, and the distance from your eyes to paperwork, and record these measurements on the form.**

Eyeglasses. Please bring your glasses that give you the best vision.

Contact Lenses. If you wear contact lenses and are happy with the comfort or vision, please wear them to the appointment and bring any packaging or a written contact lens prescription. If you wear contact lenses or if you would like to be fit into contact lenses, there will be an additional fee. The contact lens fee will depend on your situation. The fee is low if your contact lenses work well, but it will be larger if we will be fitting you into a new lens. Feel free to ask the doctor at your appointment for an estimate of the contact lens fee. Sometimes we can use your vision insurance allowance for the contact lens fee. Patients sometimes ask why we charge a contact lens fee. The reason for this is that we must perform additional tests and spend more time with contact lens wearers (including possible follow-up visits) to assure that the lenses fit well, provide the best possible vision, and are not harmful to the eyes in any way. It is typical for most eye doctors to charge a contact lens fee for time spent evaluating patients' contact lenses.

Pupillary dilation. We often consider it important to dilate our patients' pupils. This allows us to check the health of the structures inside of the eyes with more accuracy. Dilation affects different people differently. If we advise that dilation be performed, we will review with you how your vision is likely to be affected. Possible side effects **may** include blur and light sensitivity for 3 to 6 hours. We will provide disposable sunglasses if you don't have your own. Many patients can drive and function well after dilation but some cannot. If you are concerned about driving after being dilated, you may bring a driver to the exam. You may postpone the dilation to another day or even refuse the dilation, but most patients prefer to complete the dilation at the first visit. **If we are examining contact lenses at your first visit, then we will likely postpone the dilation to another day.**

Location and Parking. The Citibank building is on the north side of Colorado Blvd., across the street from Paseo Mall, between Euclid and Garfield. **Please use the parking lot in back of the Citibank building, on Union.** We will validate your parking ticket (your parking will be free). **In general, it is best to park in the lot and not on the street, as sometimes exams run longer than expected, and we don't want you to get ticketed.**

I am looking forward to meeting you at your exam!

Sincerely,

Andrew Gore, O.D.

Name		Today's date		
Home Address		City	State	Zip
Birthdate	Age	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.	
Home phone	Work phone	Cell phone		
Occupation	Employer	Hobbies	Do you drive? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please list <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Spouse		Person Responsible for Billing if not patient		
Emergency contact – name and phone number		Who referred you to our office or how did you hear about us?		
If you have any family members who are Due for an eye exam, you may list them:			Your email address	
Name of MEDICAL insurance (NOT VISION INSURANCE)	Medical insurance is under this person's name: <input type="checkbox"/> self	Relationship to you	His/her birthdate	

MEDICATIONS (pills, eyedrops, vitamins, minerals, herbal supplements, injections)	MEDICINES YOU ARE ALLERGIC TO

THE PURPOSE OF YOUR VISIT TODAY IS (please describe as needed)

<input type="checkbox"/> Problem with glasses <input type="checkbox"/> Need new glasses <input type="checkbox"/> Hard to see streetsigns <input type="checkbox"/> Hard to read fine print <input type="checkbox"/> Eye discomfort <input type="checkbox"/> Problems at the computer. Please measure: distance from eyes to screen _____ distance from eyes to paperwork _____ hours/day at computer _____	<input type="checkbox"/> Problem with contact lenses <input type="checkbox"/> Seeing flashes <input type="checkbox"/> Seeing floaters <input type="checkbox"/> Glare or light sensitivity <input type="checkbox"/> Double vision <input type="checkbox"/> You may describe these or other eye/vision problems or concerns you are having:
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YOUR EYE HISTORY

Month/Year of last eye exam	Name of eye doctor and city		
If you have had any eye or head injury , when, which eye(s) and how did it occur?	List any eye surgeries and year performed		
Have you ever been told you have any eye disease or other eye condition ?			
<input type="checkbox"/> Cataracts <input type="checkbox"/> Corneal ulcer <input type="checkbox"/> Dry eyes <input type="checkbox"/> Other:	<input type="checkbox"/> Macular degeneration <input type="checkbox"/> Strabismus/crossed eyes <input type="checkbox"/> Amblyopia (lazy eye)		
<input type="checkbox"/> Glaucoma <input type="checkbox"/> Eye infections <input type="checkbox"/> Loss of vision	<input type="checkbox"/> Retinal detachment <input type="checkbox"/> Iritis/uveitis <input type="checkbox"/> Loss of side vision		
If you wear CONTACT LENSES , do you wear <input type="checkbox"/> soft <input type="checkbox"/> rigid gas permeable			
	Contact Lens Brand Name	Power	Base Curve
Right			
Left			

FAMILY EYE AND HEALTH HISTORY

Does anyone in your **family** have any of these diseases?

<input type="checkbox"/> Glaucoma. Who?	<input type="checkbox"/> Blindness Who?
<input type="checkbox"/> Macular degeneration. Who?	<input type="checkbox"/> Diabetes. Who?
<input type="checkbox"/> Retinal detachment. Who?	<input type="checkbox"/> Other family eye diseases. Describe:

YOUR GENERAL HEALTH HISTORY

Many patients wonder why we ask for all this information. There are two main reasons. Many of these problems are sometimes associated with various eye diseases. Also, insurance companies require us to ask these questions.

Do you **smoke**? **Circle** yes / no
Do you **drink alcohol**? **Circle** yes / no
Do you use **illegal drugs**? **Circle** yes / no

Last Physical (not eye) Exam Date _____
Physician's Name and City _____

Major Surgeries (not eye) **When**

Recent Hospitalizations When
Purpose _____
Purpose _____

Pregnancy
 I am **pregnant** now I am **nursing** now

Blood Conditions
 Bleeding problems _____
 Other. Describe _____

Cancer
 Type, location, when diagnosed and how treated _____

Cardiovascular/Vascular Conditions
 High blood pressure
Control is good/bad (**circle**)
 Heart attack. When _____
 Heart disease. Describe _____
 Congestive heart failure
 Temporal arteritis High Cholesterol
 Other. Describe _____

Constitutional Problems
 Weight loss/gain, fever, lower energy level
 Other. Describe _____

Ears
 Decreased hearing
 Other. Describe _____

Endocrine Conditions
 Diabetes. Year of diagnosis _____
Average blood sugar _____
Most recent hemoglobin A1C _____
Vision fluctuates after food? **Circle** Yes/No
 Thyroid problem
 Other. Describe _____

Gastrointestinal Conditions
 Crohn's disease
 Other. Describe _____

Genitourinary Conditions
 Benign prostate enlargement
 Genitals/kidney/bladder _____
 Other. Describe _____

Immune Conditions
 Sjogren's syndrome Lupus
 HIV. Year of diagnosis _____
Latest T cell count _____
 Other. Describe _____

Infectious Diseases
 Hepatitis type _____
 Gonorrhea Syphilis
 Other. Describe _____

Musculoskeletal Conditions
 Osteoarthritis Rheumatoid arthritis
 Psoriatic arthritis Gout
 Reiter's syndrome Myasthenia gravis
 Ankylosing spondylitis
 Other. Describe _____

Neurological/Psychiatric Conditions
 Headaches Migraines
 Depression Multiple Sclerosis
 TIA (pre-stroke). When? _____
 Stroke. When, and did it affect your vision _____
 Other. Describe _____

Respiratory Conditions
 Seasonal allergy Asthma
 Emphysema Chronic bronchitis
 Dry throat/mouth
 Other. Describe _____

Skin Conditions
 Rosacea
 Skin cancer. Type and location: _____
 Other. Describe _____

Other Conditions Not Listed Above:
Reviewed by Dr. _____ on _____
Re-reviewed by Dr. _____ on _____
Re-reviewed by Dr. _____ on _____
Re-reviewed by Dr. _____ on _____