ANDREW GORE, O.D.
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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, as 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.

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Name			Today's date		
Home Address			City	State	Zip
Birthdate	Age	☐ Male ☐ Female	Social Security No.		
Home phone	Work phone		Cell phone		
Occupation	Employer		Hobbies	Do you drive? ☐Yes ☐No	
Please list ☐Parent ☐Guardian ☐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:			**EMAIL ADDRESS (Helpful for recalls or if the doctor needs to contact you)**		

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

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

- ☐ Need new glasses ☐ Problem with glasses
- ☐ Eye discomfort
- ☐ Hard to see streetsigns
- ☐ Hard to read fine print
- ☐ Problems at the computer. **PLEASE MEASURE:**
  distance from eyes to screen _____
  distance from eyes to paperwork _____
  hours/day at computer _____
- ☐ Need contact lenses ☐ Problem w/contact lenses
- ☐ Seeing flashes ☐ Seeing floaters
- ☐ Double vision ☐ Glare ☐Light sensitivity
- ☐ You may describe these or other eye/vision problems or concerns you are having:

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**?

- ☐ Cataracts ☐ Macular degeneration ☐ Glaucoma ☐ Retinal detachment
- ☐ Corneal ulcer ☐ Strabismus/crossed eyes ☐ Eye infections ☐ Iritis/uveitis
- ☐ Dry eyes ☐ Amblyopia (lazy eye) ☐ Loss of vision ☐ Loss of side vision
- ☐ Other:

If you wear **CONTACT LENSES**, do you wear ☐ soft ☐ rigid gas permeable

	Contact Lens Brand Name	**Power**	**Base Curve**
Right			
Left			

FAMILY EYE AND HEALTH HISTORY

Does a **BLOOD RELATIVE** have any of these diseases?

- ☐ **Glaucoma**. Who?
- ☐ **Macular degeneration**. Who?
- ☐ **Retinal detachment**. Who?
- ☐ **Blindness** Who?
- ☐ **Diabetes**. Who?
- ☐ **Other family eye diseases**. Describe:

(THIS IS A 2-SIDED FORM. PLEASE TURN PAGE OVER.)

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YOUR GENERAL HEALTH HISTORY

Many patients wonder why we ask for all this information. 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 Exam (NOT EYE) 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 Doc	Date	Color Pen