Date:_____

FAMILY EYE CARE
DR. WILLIAM GORDON

Welcome to Our Office!!!
Medical History Questionnaire

Name _____Sex: ☐M ☐F DOB _____Age _____
Street _____City _____ Zip Code _____
Home Phone _____ Cell Phone _____ For Emergencies Please Call _____
Spouse (or Parents') Name _____ Spouse (or Parents') Work Phone_____
Employer (or School) _____Work Phone_____
Occupation (or Grade) _____Your Email Address_____
Insurance Information_____
Your insurance company may require your Social Security number (ie. VSP) SS #_____

How did you hear about Family Eye Care?

☐ Referred—by whom?_____
☐ I received a recall letter
☐ Family Eye Care is a provider for my insurance plan.
☐ Yellow Pages
☐ Other _____

Are you interested in (Check all that apply)….?

☐ New Glasses ☐ Laser Surgery ☐ Invisible Bifocals
☐ Contact Lenses ☐ Computer Glasses ☐ Spare Glasses
☐ Safety Glasses ☐ Sunglasses ☐ UV Protection
☐ Anti Glare ☐ Thin, Light Lenses ☐ Sports Glasses

When was your last eye exam?_____Where was your last eye exam?_____
What is the main reason for your visit today?_____

Medical History

Do you have any allergies to medications? ❒ No ❒ Yes If yes, please explain:_____
List all major injuries, surgeries and/or hospitalizations you have had:_____.
List any of the following that you have had: Crossed Eyes, Lazy Eye, Drooping Eyelid, Prominent Eyes, Glaucoma, Retinal Disease, Cataracts, Eye Infections or Eye Injury:_____
Are you pregnant and or nursing? ☐Yes ☐No
Do you wear glasses? ☐ Yes ☐ No If yes, how old is your present pair of lenses?_____
Do you wear contact lenses? ☐ Yes ☐ No If yes, how old is your present pair of lenses?_____
Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other Are they comfortable? ☐ Yes ☐ No

Family History

Please note any family history (Parents, Grandparents, Siblings, Children: living or deceased) for the following conditions:

Do you or any Blood Relatives have any of the following:	**YOU**	**BLOOD RELATIVE (WHO?)**
Cataract	☐	☐ _____
Crossed Eyes	☐	☐ _____
Glaucoma	☐	☐ _____
Macular Degeneration	☐	☐ _____
Retinal Detach/Disease	☐	☐ _____
Lazy Eye/Amblyopia	☐	☐ _____
Headaches	☐	☐ _____
Double Vision	☐	☐ _____
Arthritis	☐	☐ _____
Cancer	☐	☐ _____
Diabetes	☐	☐ _____
Heart Disease	☐	☐ _____
High Blood Pressure	☐	☐ _____
Kidney Disease	☐	☐ _____
Lupus	☐	☐ _____
Thyroid Disease	☐	☐ _____
Other	☐	☐ _____

Please List All Medications <u>You</u> Are Taking
(Including Birth Control or any Non-Prescription Medications)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(Please Turn Over & Fill Out Both Sides) Thank You!

Social History: This information is kept strictly confidential! However, you may discuss this portion directly with the doctor if you prefer.
☐ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check Box)
Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes If Yes, please describe:

_____

Do you use tobacco products? ☐ No ☐ Yes If Yes, type/amount/how long:_____
Do you drink alcohol? ☐ No ☐ Yes If Yes, type/amount/how long: _____
Do you use illegal drugs? ☐ No ☐ Yes If Yes, type/amount/how long:_____
Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of Systems

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

System	No	Yes	?
Constitutional			
Fever, Weight Loss/Gain	☐	☐	☐
Integumentary (Skin)	☐	☐	☐
Neurological			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Eyes			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Haloes	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
Endocrine			
Thyroid/Other Glands	☐	☐	☐

	No	Yes	?
Ears, Nose, Mouth, Throat			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Vascular/Cardiovascular			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
Gastrointestinal			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Genitourinary			
Genitals/Kidney/Bladder	☐	☐	☐
Bones / Joints / Muscles			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
Lymphatic / Hematologic			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
Allergic / Immunologic	☐	☐	☐
Psychiatric	☐	☐	☐

If you answered Yes to any of the above or have a condition not listed, please explain & list medications:

_____
_____
_____
_____
_____
_____
_____

We will file all insurance forms if Family Eye Care is a participating provider for your plan.
We will supply you with an itemized statement which you may submit to your insurance carrier.
PAYMENT IN FULL IS REQUIRED AT TIME OF SERVICE. BILLING CHARGES APPLY.

_____ _____
Patient Signature **Date**