Date:_____

FAMILY eye care
Dr. William D. Gordon • Dr. Anthony Lamar

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

## 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 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:

_____
_____
_____
_____
_____
_____
_____

_____ _____

**Doctor's Signature** **Date**