Medical History Questionnaire

Advance Family EyeCare 5832 N Main St Joplin, MO 64801 (417) 623-7900 Fax: (417) 623-0559

Name: ______________________ Today's Date: ____________
Birth Date: ____________ Social Security #: ____________ Last Exam Date: ____________
Name of Medical Doctor: ______________________ Dr.'s Phone: ____________
Current Occupation: ______________________ Last Medical Exam: ____________

Medical History

Do you have allergies to medications? ☐No ☐Yes If yes, explain: ____________

List any **Medications/ Dosages/Frequency** you take (including oral contraceptives, aspirin, over the counter medications): ____________

List all major injuries, surgeries and/or hospitalizations you have had: ____________

List all of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, burning, watering, itching, eye infections or eye injury? ____________

Are you pregnant and/or nursing? ☐No ☐Yes

Do you wear glasses? ☐No ☐Yes **If yes, how old** is your present pair of lenses? ____________

Do you wear or have you worn contact lenses? ☐No ☐Yes If yes, how old is your **present** pair of lenses? ____________

Type of Contact lenses: ☐Hard ☐Soft ☐Extended Wear ☐Other Are they comfortable? ☐Yes ☐No

Family History

Please note any family history (yourself, parents, grandparents, siblings, children, living or deceased) for the following conditions:

DISEASE/CONDITION	SELF	FAMILY	RELATIONSHIP TO YOU
Blindness	☐	☐	
Cataract	☐	☐	
Crossed Eyes	☐	☐	
Glaucoma	☐	☐	
Macular Degeneration	☐	☐	
Retinal Detachment/Disease	☐	☐	
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 your 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 been exposed to or infected with: ☐Gonorrhea ☐Hepatitis ☐HIV ☐Syphilis ☐No

**** Please turn this form over and complete side two ****

Review of Systems

	NO	YES		EXPLAIN/LIST MEDICATIONS
CONSTITUTIONAL				
Fever	☐	☐	☐	
Weight loss and/or gain	☐	☐	☐	
INTEGUMENTARY				
Rash	☐	☐	☐	
NEUROLOGICAL				
Headaches	☐	☐	☐	
Migraines	☐	☐	☐	
Seizures	☐	☐	☐	
Stroke	☐	☐	☐	
Paralysis	☐	☐	☐	
EYES				
Loss of Vision	☐	☐	☐	
Blurred Vision	☐	☐	☐	
Itch and/or Burning	☐	☐	☐	
Tearing	☐	☐	☐	
Glare and/or Light sensitivity	☐	☐	☐	
Eye Pain	☐	☐	☐	
Redness	☐	☐	☐	
Flashes and/or Floaters	☐	☐	☐	
Tired Eyes	☐	☐	☐	
Jaw Pain	☐	☐	☐	
Scalp Tenderness	☐	☐	☐	
Amaurosis Fugax	☐	☐	☐	
ALLERGIC/IMMUNOLOGIC				
Allergies	☐	☐	☐	
Hay Fever	☐	☐	☐	
Chronic Cough	☐	☐	☐	
Dry Throat/Mouth	☐	☐	☐	
EAR, NOSE, THROAT and MOUTH				
Stuffy and/or Runny Nose	☐	☐	☐	
Ear Ache	☐	☐	☐	
Dry Mouth	☐	☐	☐	
RESPIRATORY				
Cough	☐	☐	☐	
Congestion	☐	☐	☐	
Wheezing	☐	☐	☐	
Shortness of Breath	☐	☐	☐	
Asthma	☐	☐	☐	
Emphysema	☐	☐	☐	
CARDIOVASCULAR				
High Blood Pressure	☐	☐	☐	
Rapid Heart Beat	☐	☐	☐	
GASTROINTESTINAL (G.I.)				
Diarrhea	☐	☐	☐	
Constipation	☐	☐	☐	
GENITOURINARY (G.U.)				
Burning on Urination	☐	☐	☐	
Urinary Frequently	☐	☐	☐	
Incontinence	☐	☐	☐	
Upset Stomach	☐	☐	☐	
MUSCULOSKELETAL				
Arthritis	☐	☐	☐	
Joint Pains	☐	☐	☐	
Stiffness	☐	☐	☐	
HEMATOLOGIC/LYMPHATIC				
Anemia	☐	☐	☐	
Cholesterol, High	☐	☐	☐	
ENDOCRINE				
Diabetes	☐	☐	☐	
Thyroid	☐	☐	☐	

PSYCHIATRIC ☐ Anxiety ☐ Depression ☐ Insomnia ____________________

Sign ______________________________

Relationship to patient: ______________ Date ______________ Drs. signature ____________________