

Medical History Questionnaire

Advance Family EyeCare

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Joplin, MO 64801

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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 you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

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: Rigid 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	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 ***