

Welcome to Advanced Vision Care

Medical History Questionnaire

Mr., Mrs., Ms., Miss _____ Sex: _____ Marital status: _____ Today's date: _____
Address: _____ Birthdate: _____ Age: _____
City / State / Zip: _____ SSN: _____
Home phone: _____ Work phone: _____

Responsible Party: _____ Employer: _____
Address if different: _____ Occupation: _____
Is this your first visit to our office? _____ I was recommended by: _____

When was your last eye exam: _____ email address: _____
Have you ever worn glasses? _____ For: Distance, Near, or Both (circle one)
Reason for today's visit: _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, eye surgery or eye injury:

Do you have any medication allergies? no yes If yes, please explain:

Do you have any other allergies? no yes If yes, please explain:

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

Who is your primary physician? _____ Approximate date of last exam: _____

Are you pregnant and/or nursing? no yes

Contact Lens History:

I am interested in contact lenses as a new wearer

I currently wear contacts and would like them updated

Brand / type: _____

How often do you change them: _____

Problems: _____

I have worn contacts in the past

Brand / type:

How long ago:

Glasses Interests:

I am interested in glasses for:

Golf Baseball Snow skiing Swimming Hunting
Safety Sun protection Night driving Computer work Other

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Do you drive? no yes

If yes, do you have visual difficulty when driving? no yes

If yes, please describe:

Do you use tobacco/cigarettes? 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 None

Family History

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

Disease/ Condition	NO	Yes	?	Relationship to you
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Retinal Detachment/ Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Review of Systems

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

SYSTEM	NO	YES	?	SYSTEM	NO	YES	?
CONSTITUTIONAL				EAR, NOSE, MOUTH, THROAT			
Fever, Weight Loss/ Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/ Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY (SKIN)				Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL				Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/ Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EYES				RESPIRATORY			
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/ Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VASCULAR / CARDIOVASCULAR			
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL			
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY			
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/ Kidney/ Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Tearing/ Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BONE / JOINTS			
Glare/ Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye / Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC/ HEMATOLOGIC			
Flashes or Floaters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE				ALLERGIC / IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/ Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

If you answered YES to any of the above or have a condition not listed, please explain here:

Doctor's Signature:

Date: