

LONG ISLAND EYE SURGEONS MEDICAL HISTORY QUESTIONNAIRE

rev4/08

FIRST NAME	LAST NAME	Date: _____
		Referring Dr: _____
Home Telephone: _____	Daytime Tel: (<input type="checkbox"/> same as home)	Cell-phone: _____
List all medications(you may use the back of this sheet): <input type="checkbox"/> None		
Allergies to medications: <input type="checkbox"/> None		
List all medical conditions: <input type="checkbox"/> None		
List all previous surgeries: <input type="checkbox"/> None		

SYMPTOMS

- | | |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Recent vision loss | <input type="checkbox"/> Yes <input type="checkbox"/> No Floaters |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Flashes of light | <input type="checkbox"/> Yes <input type="checkbox"/> No Loss of peripheral vision |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Nighttime glare | <input type="checkbox"/> Yes <input type="checkbox"/> No Tired eyes |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Double vision | <input type="checkbox"/> Yes <input type="checkbox"/> No Dryness |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Tearing | <input type="checkbox"/> Yes <input type="checkbox"/> No Eye discharge |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Redness | <input type="checkbox"/> Yes <input type="checkbox"/> No Sandy/gritty feeling |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Itching | <input type="checkbox"/> Yes <input type="checkbox"/> No Eye pain/burning |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Foreign body sensation | <input type="checkbox"/> Yes <input type="checkbox"/> No Eyelid swelling |

Please use this space to explain further:

--

GENERAL MEDICAL REVIEW (explain further in space provided)

- Yes No Fever _____
- Yes No Weight loss _____
- Yes No Ears/Nose/Throat (sinus /ear infections, chronic cough, dry mouth...) _____
- Yes No Cardiovascular (heart, vessels etc.) _____
- Yes No Respiratory (Asthma, emphysema, etc.) _____
- Yes No Gastrointestinal (Stomach ulcers, intestinal disease, etc.) _____
- Yes No Genital, Kidney, Bladder, Prostate _____
- Yes No Muscle, Bone, Joints _____
- Yes No Skin (acne, warts, skin cancer etc.) _____
- Yes No Neurological (multiple sclerosis, strokes, brain tumors etc) _____
- Yes No Psychiatric (depression, anxiety, ADHD etc) _____
- Yes No Endocrine (diabetes, thyroid etc) _____
- Yes No Blood/Lymphatics _____
- Yes No Allergic (seasonal, food, pet allergies etc.) _____
- Yes No Have you ever taken Flomax? _____
- Yes No Do you take blood thinners (Aspirin, Coumadin, Plavix, Vitamin E)? _____

FAMILY HISTORY (write relation next to illness)

- | | |
|---|---|
| <input type="checkbox"/> Blindness _____ | <input type="checkbox"/> Retinal detachments _____ |
| <input type="checkbox"/> Glaucoma _____ | <input type="checkbox"/> Macular. degeneration _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Heart disease or high blood pressure _____ |
| <input type="checkbox"/> Kidney disease _____ | <input type="checkbox"/> Lupus _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Thyroid diseases _____ |
| <input type="checkbox"/> Other _____ | |

P: Parents
S: Siblings
GP: Grandparents
CH: Children
AU: Aunt or uncle
CO: Cousins

SOCIAL INFORMATION

- Occupation: _____ Retired Student
- Marital status: Single Married Divorced Widowed
- Lives lives alone with _____
- Do you drive? Yes No
- Do you wear contacts? Yes No
- How often do you drink? Never Occasionally Once daily 2-3 per day 4+ per day
- Do you smoke? Never Occasionally 1/2 pack daily 1 pack daily >1 pack daily

THIS SECTION IS FOR STAFF ONLY

Phys. Signature _____ Date _____	Phys. Signature _____ Date _____
Phys. Signature _____ Date _____	Phys. Signature _____ Date _____