LONG ISLAND EYE SURGEONS MEDICAL HISTORY QUESTIONNAIRE

FIRST NAME	LAST NAME	Date:
		Referring Dr:
Home Telephone:	Daytime Tel: (☐same as home)	Cell-phone:
List all medications(you may use the back of this sheet): ☐None		
Allergies to medications: ☐None		
List all medical conditions: ☐None		
List all previous surgeries: ☐None		

SYMPTOMS

☐Yes ☐No Recent vision loss
☐Yes ☐No Flashes of light
☐Yes ☐No Nighttime glare
☐Yes ☐No Double vision
☐Yes ☐No Tearing
☐Yes ☐No Redness
☐Yes ☐No Itching
☐Yes ☐No Foreign body sensation
☐Yes ☐No Floaters
☐Yes ☐No Loss of peripheral vision
☐Yes ☐No Tired eyes
☐Yes ☐No Dryness
☐Yes ☐No Eye discharge
☐Yes ☐No Sandy/gritty feeling
☐Yes ☐No Eye pain/burning
☐Yes ☐No Eyelid swelling

Please use this space to explain further:

GENERAL MEDICAL REVIEW (explain further in space provided)

What is your estimated **Height** _____ ft _____ inches & **Weight** __________ lbs

☐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, Tamsulosin, Terazosin, Rapaflo or Cardura?
☐Yes ☐No Do you take blood thinners (Aspirin, Coumadin, Plavix, Vitamin E)? ____________________

FAMILY HISTORY (write relation next to illness)

☐Blindness _____
☐Glaucoma _____
☐Diabetes _____
☐Kidney disease _____
☐Stroke _____
☐Other______________________________
☐Retinal detachments _____
☐Macular. degeneration _____
☐Heart disease or high blood pressure _____
☐Lupus _____
☐Thyroid diseases _____

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 ________