Long Island Pediatric Ophthalmology and Strabismus, P.C.

Adult New Patient History Questionnaire

Patients Name_____ Sex ❑M ❑F Today's Date _____

Date of Birth _____ Age _____ Date of Office Visit_____

Primary Care Physician _____Date of Last Exam_____

Referred By:_____ Other Health Care Providers: _____Specialty?_____

_____Specialty?_____

Other Family Members Seen Here _____

Medication Allergies: (Please List Drug and Reaction)

Reason for Visit:
_____
_____

Eye History: Have you ever had: (if yes, give details)

eyeglasses or contacts?	❑No ❑Yes	(still wearing? how often?) _____
eye disease or eye surgery?	❑No ❑Yes	_____
eye turn or lazy eye?	❑No ❑Yes	(which eye?) _____
patching?	❑No ❑Yes	
eye exercises?	❑No ❑Yes	(how long?)_____

Medical History: Have there been any: (if yes, give details)
major illnesses, hospitalizations, injuries? ❑No ❑Yes _____
operations or surgeries? ❑No ❑Yes _____

Current Medications: ❑None (if currently taking a medication, list the drug, reason for taking, and dose)
Drug _____ Reason _____ Dose _____
Drug _____ Reason _____ Dose _____
Drug _____ Reason _____ Dose _____

Social History:
Current Occupation_____
Marital Status_____

Do you live alone?	❑No ❑Yes
Do you drive?	❑No ❑Yes
Do you use tobacco?	❑No ❑Yes (how much, how long?)_____
Do you use alcohol?	❑No ❑Yes (how often?)_____ glasses every ❑day ❑week ❑month

Hobbies or special interests_____

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Family History:
Are there any family members who have had eye turn, eye muscle surgery, amblyopia (lazy eye), patching or exercises in childhood, glaucoma, genetic eye diseases, retinal detachment, blindness, or other serious eye disorder?
❑No ❑Yes

_____
_____
_____

Review of Systems: (Are you currently experiencing any of the following symptoms? If yes, please give details.)

Eyes:

❑No symptoms	❑Yes (please check below)		
❑eye turn	❑eye pain	❑excessive blinking	❑spots or floaters
❑double vision	❑red eyes	❑excessive rubbing	❑abnormal head position
❑blurred vision	❑tearing	❑squinting	❑distorted vision
❑light sensitivity	❑discharge	❑droopy eyelid	❑other
❑loss of vision	❑itchy eyes	❑swollen eyelid	

details:

_____
_____
_____

General: (fever, fatigue, weight loss)	❑No ❑Yes	_____
Ears, Nose, Throat Problems	❑No ❑Yes	_____
Allergies (food, environmental)	❑No ❑Yes	_____
Cardiovascular (blood pressure, pulse)	❑No ❑Yes	_____
Respiratory (asthma, cough)	❑No ❑Yes	_____
Gastrointestinal (nausea, vomiting, bowel problems)	❑No ❑Yes	_____
Kidney, Bladder, Genital Problems	❑No ❑Yes	_____
Muscles, Joints, Bones (arthritis, pains)	❑No ❑Yes	_____
Skin (rashes, moles)	❑No ❑Yes	_____
Neurological (headache, weakness, habits)	❑No ❑Yes	_____
Psychiatric (anxiety, depression, insomnia)	❑No ❑Yes	_____
Endocrine (diabetes, thyroid)	❑No ❑Yes	_____
Blood (anemia, bleeding problem)	❑No ❑Yes	_____

History Questionnaire Completed By: _____(signature)

For Office Use Only:
History Reviewed: _____
Signature Date