Long Island Pediatric Ophthalmology and Strabismus, P.C.

Adult Returning Patient History Questionnaire

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

Date of Birth _____ Age _____ Date of Office Visit_____

Primary Care Physician _____

Medication Allergies: (Please List Drug and Reaction)

Reason for Visit:
_____
_____

Eye History: Have you had any NEW eye problems , injuries, or surgeries since the last visit?
❑No ❑Yes (details)_____
_____
_____

Medical History: Have there been any NEW: (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:
Changes in occupation? ❑No ❑Yes (details) _____
Changes in marital status? ❑No ❑Yes _____
Changes in living arrangements? ❑No ❑Yes _____
Changes in driving habits? ❑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

Family History:
Have there been any NEW eye problems in the family? ❑No ❑Yes (details) _____
_____
_____
_____

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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