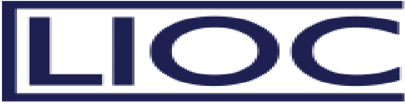

LONG ISLAND OPHTHALMIC CONCEPTS
TRANSFORMING EYECARE

New Patient Medical History Questionnaire

revised 07/21/2017

George Tung, MD

☐ 2450 Merrick Rd, Bellmore, NY 11710
☐ 560 Northern Blvd, Great Neck, NY 11020
☐ 158 Main St, Huntington, NY 11743
☐ 54-44 Little Neck Pkwy #3, Little Neck, NY 11362

Name ______________________________ Date ____________

Date of birth ____________ Name of primary care physician ____________________

Date of last eye exam ____________ Date of last medical exam ____________

Have you seen an ophthalmologist before? ☐ yes, date of last visit ____________ ☐ no

Name of ophthalmologist seen ______________________________

Current medications (list all prescribed and over-the-counter medications you are now taking and their dosages, including eye drops, birth control pills, diuretics or water pills, blood pressure or heart medications) ____________________

Please circle any of the following you are currently taking: **High risk medication that require Visual Fields:** plaquenil, Topamax, epilepsy meds, amiodarone, flomax, tamoxifen, prednisone, interferon, viagra

Do you have allergies to any medications: ☐ yes ☐ no Are you allergic to Latex? ☐ yes ☐ no

If YES, list the medications: ______________________________

List all major illnesses (glaucoma, diabetes, blood pressure, heart attack, stent placement, etc.) or injuries (concussion, etc.): ____________

____

List any surgeries you have had (cataract, tonsillectomy, appendectomy): ____________________

____

Have you ever been diagnosed with cancer? ☐ yes ☐ no Dates of diagnosis and treatment received: ____________

____

Do you currently have any problems in the following areas? If "YES", please provide information.

	YES	NO	Explanation of Problem
EYES (glaucoma, cataract, retinal disease)			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness/Swollen			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light-sensitivity			
Eye pain or soreness			
Infection of eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			

(over) (over) (over) (over)

LONG ISLAND OPHTHALMIC CONCEPTS
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Medical History Questionnaire (page 2)

GEORGE TUNG, MD
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Name

	YES	NO	Explanation of Problem
EARS, NOSE, THROAT (sinus, ear infection, chronic cough, dry mouth)			
CARDIOVASCULAR (heart, vessels)			
RESPIRATORY (asthma, emphysema)			
GASTROINTETINAL (stomach ulcers)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (arthritis)			
SKIN (acne, rosacea, skin cancer)			
NEUROLOGICAL (headaches)			
PSYCHIATRIC (stress, anxiety, depression)			
ENDOCRINE (diabetes, thyroid)			
BLOOD, LYMPH (anemia)			
ALLERGIC, IMMUNOLOGIC (hay fever)			

FAMILY HISTORY M=mother F=father S=sibling GP=grandparent

	YES	NO	Relationship to Patient
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current occupation ______________________

Education (high school, vocational school, college degree) ______________________

Marital Status (married, divorced, single, widowed) ______________________

Living Arrangements ______________________

Do you drive? ☐ yes ☐ no

Do you have visual difficulty when driving? ☐ yes ☐ no

Do you have problems with night vision? ☐ yes ☐ no

Do you wear eyeglasses? ☐ yes ☐ no

When was last Rx filled? ______________ Where made? ______________

Do you wear contact lenses? ☐ yes ☐ no If YES, hard ( ) soft ( ) daily ( ) extended ( )

How long have you worn contact lenses? ______________ What brand do you wear? ______________

Where do you get your contact lenses from? ______________ ______________

Do you drink alcohol? ☐ yes ☐ no If YES: occasional 1/day 2-3/day 4+/day

Do you smoke? ☐ yes ☐ no If YES: occasional 1/2 pack/day 1 pack/day 1+ pack/day

Signature of Patient or Other (if other, please indicate relation) MD initials