LONG ISLAND OPHTHALMIC CONCEPTS
TRANSFORMING EYECARE

Primary Location of Care:

Bellmore ☐ Great Neck ☐ Huntington ☐ Little Neck ☐

Emergency Visit

Date ____________________

Name ____ Date of last eye exam ________________

What is reason for today's emergency visit? ____

What current or new medications (Rx and over-the-counter) do you currently take? ____________________

____

Do you have any new allergies to medication since your last visit? ☐ yes ☐ no

If YES, list the medications: ____

Have you had any major illnesses or injuries since your last visit? ____________________________

Have you had any surgeries since your last visit? ____________________________________

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

	YES	NO	Explanation of Problem
EYES			
GENERAL/ CONSTITUTIONAL			
EARS, NOSE, THROAT			
CARDIOVASCULAR			
RESPIRATORY (asthma, emphysema)			
GASTROINTESTINAL (stomach ulcers)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (arthritis)			
SKIN (rosacea, rashes)			
NEUROLOGICAL (headaches)			
PSYCHIATRIC (stress, anxiety, depression)			
ENDOCRINE (diabetes, thyroid)			
BLOOD, LYMPH			
ALLERGIC, IMMUNOLOGIC			

FAMILY

Any changes in family medical status (mother, sibling, grandparent)? ☐ Yes ☐ No

If YES describe: ____

SOCIAL

Changes of Employment? ____

Marital Status (married, divorced, widowed) ________________________________

Living Arrangements: ____

Do you drive? ☐ Yes ☐ No

Do you have visual difficulty driving? ☐ Yes ☐ No

Do you have problems with night vision? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No If YES: occasional 1/2 day 2/3 day 4+/ day

Do you smoke? ☐ Yes ☐ No If YES: occasional 1/2 pack/ day 1 pack day 1+ pack/ day

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