LONG ISLAND OPHTHALMIC CONCEPTS
TRANSFORMING EYECARE

Primary Location of Care:

Bellmore ☐ **Great Neck** ☐ **Huntington** ☐ **Little Neck** ☐

Medical History Questionaire Existing Patient

Name _____ Date _____

Current medications all prescibed and over the counter medications you are now taking and their dosages including eye drops and birth control pills, diuretics or water pills, blood pressure or heart medications _____

_____

Any changes in medical history? _____

Any changes in your family history? _____

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			
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			
Drooping eyelid			
Fever			
Weight loss /gain			
Other			