NY Vision Group
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PATIENT HISTORY QUESTIONNAIRE

To all patients:

The following questionnaire is intended to help us better evaluate and treat your medical problems. We appreciate you filling it out in its entirety; should you have any questions about what information to include, please do not hesitate to ask the office staff. Thank you.

Name:_____**Date of Birth:**_____**Date:** _____

1. What is the medical problem that you believe needs to be addressed?

_____

2. Do you wear glasses? Y ☐ N ☐
3. Do you wear contacts? Y ☐ N ☐
4. Do you need or want a contact lens prescription? Y ☐ N ☐
5. Are you interested in learning more about Laser Vision Correction (LASIK)? Y ☐ N ☐

REVIEW OF SYMPTOMS:

Do you presently have any problems in the following areas? Check all that apply and provide explanation.

General Symptoms
- Fever ☐
- Weight Loss ☐
- Other ☐

Eyes
- Loss of Vision ☐
- Blurred Vision ☐
- Distorted Vision ☐ (halos)
- Loss of side vision ☐
- Double vision ☐
- Dryness ☐
- Discharge ☐
- Redness ☐
- Sandy/gritty feeling ☐
- Itching/burning ☐
- Foreign body sensation ☐
- Excess tearing ☐
- Glare/Light sensitivity ☐
- Eye pain or soreness ☐
- Chronic infection ☐
- Styes, chalazion ☐
- Floater ☐ Flashes of light ☐
- Tired eyes ☐

Hematologic
- Blood ☐
- Swelling ☐

Allergic/Immunologic
- Head Allergy ☐
- Seasonal/Hay fever ☐

Ears, Nose, Mouth
- Sinus Congestion ☐
- Runny Nose ☐
- Post nasal drip ☐
- Chronic cough ☐
- Dry throat/mouth ☐

Cardiovascular
- Heart/blood vessels ☐

Respiratory
- Lungs/breathing ☐
- Chronic bronchitis ☐

Gastrointestinal
- Stomach/intestines ☐

Musculoskeletal
- Muscle/joint ☐

Integumentary
- Skin and or breast ☐

Neurological ☐

Psychiatric ☐

Endocrine
- Thyroid ☐

Other ☐_____

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PATIENT HISTORY QUESTIONNAIRE (continued)

Name:_____ **Date of Birth:**_____ **Date:** _____

EXPLANATION OF SYMPTOMS:

_____

_____

PAST MEDICAL HISTORY/CURRENT ILLNESSES (CHECK ALL THAT APPLY):

Anemia ☐
Arthritis ☐
Asthma ☐
Bladder Disease ☐
Bleeding Tendencies ☐
Bronchitis ☐
Cancer ☐ What Type:
Cataracts ☐
Chicken Pox ☐
Dementia(Memory Problems) ☐
Diabetes ☐
Emphysema ☐
Gallbladder Problems ☐
Glaucoma ☐
Heart Disease ☐
Hearing Loss ☐
Hepatitis ☐ A__B__C__
High Blood Pressure ☐
HIV ☐
Mental Illness ☐
Influenza ☐
Jaundice ☐
Kidney Failure ☐
Kidney Stones ☐
Measles ☐
Hyperlipidemia (high cholesterol or triglycerides) ☐
Mumps ☐
Pregnant ☐ Specify due date:
Reflux ☐
Seizures ☐
Skin Lesions/Rash ☐
Sickle Cell Disease ☐
Stroke ☐
Tuberculosis ☐
Thyroid Disease ☐
Sexually Transmitted Disease☐
Other ☐_____
_____
_____

Operations/Hospitalizations:_____

_____

Medications/Dietary/Herbal Supplements:

_____

_____

List Allergies or Reactions to Medications:

_____

PATIENT HABITS:

	Present	Past	Amount
Tobacco (cigarettes, chewing, pipes, cigars)	Y ☐ N ☐	Y ☐ N ☐	_____
Alcohol	Y ☐ N ☐	Y ☐ N ☐	_____
Exercise	Y ☐ N ☐	Y ☐ N ☐	_____
Illicit Drugs	Y ☐ N ☐	Y ☐ N ☐	_____

Type of Drugs_____

FAMILY HISTORY: (check those that a family member has had)

Alzheimer's Disease ☐
ARMD ☐
Asthma ☐
Arthritis ☐
Thyroid Disease ☐
Cancer ☐
Diabetes ☐
Epilepsy ☐
Glaucoma ☐
Other: ☐
Heart Problems ☐
High Blood Pressure ☐
Kidney Disease ☐
Retinal Disease ☐